THE UNIVERSITY OF ALBERTA

LIVEBIRTH FOLLOWING STILLBIRTH: MATERNAL PROCESSES

by

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©

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SILENT CRIES*

I never got to hold your hand
nor tell you that I care...
I never got to see your smile,
the laughter isn't there.

The world seemed so cruel and callous
to take my only son...
But hold on strong my angel,
for again we will be one.

I hold you truly in my heart
that's where you'll never die...
My baby son, Cory James
with your spirit in the sky.

*Written by one of the mothers in this study and included with permission.

THE UNIVERSITY OF ALBERTA

FACULTY OF GRADUATE STUDIES AND RESEARCH

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research, for acceptance, a thesis entitled LIVEBIRTH FOLLOWING STILLBIRTH: MATERNAL PROCESSES submitted by Elizabeth Ann Lever Hense in partial fulfilment of the requirements for the degree of MASTER OF NURSING.

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DEDICATION

This is dedicated to the women who willingly participated in the study and shared their most intimate thoughts and feelings in hopes that they might help other women who experience the tragedy of stillbirth.

It is lovingly dedicated to my mother who taught me the importance of education and supported me always.

ABSTRACT

For a woman who experiences a stillbirth, the loss of the child can be devastating. Although the reactions of women to stillbirth have been studied, little research has addressed the effect that having a stillbirth has on a subsequent pregnancy. The purpose of the study was to identify perinatal maternal processes that occur with livebirth subsequent to stillbirth. The grounded theory method was used to develop a beginning theory to explain these processes.

Eleven women who had experienced a perinatal loss were selected to be study informants. Ten of these women were pregnant when they participated in the study. Unstructured tape recorded interviews were conducted with the informants. Interviews were held from 23 weeks gestation to six weeks postpartum, with four of the informants being interviewed both antenatally and postnatally. The constant comparison method was used to analyze the data obtained in the transcripts and field notes. The key concepts identified in the data were coded into categories. The categories were defined, developed and integrated to generate a beginning theory.

The major social psychological process occurring when women became pregnant following a stillbirth was fearing recurrence of loss. As a consequence of fearing recurrence of loss the women were hesitant to begin attaching to their unborn child while at the same time being protective of the unborn child. Although relieved with the birth of a healthy child, informants continued to fear that something untoward might happen to their child. Mothers tended to be overprotective of the child and lacked confidence in the mothering role. Residual grief for the stillborn child was rekindled with the birth of the live child. While developing a relationship with the live child, mothers proceeded to acknowledge the stillborn child and differentiate between the two children. Propositions based on this beginning theory were developed.

The beginning theory that was developed regarding the process of livebirth following stillbirth can be used by nurses to plan and implement appropriate nursing care for women who have had a stillbirth and are pregnant again. In addition, questions for further nursing research were identified.

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Chapter I

INTRODUCTION

> They figure that, because you weren't actually bringing that child up that you can't miss it. Or miss the whatever. They don't understand that (sighs) having it growing and feeling the expectations, you know. Wanting to be that mother and then all of a sudden, nothing. They don't understand the attachment you felt. They say "Oh well, it just wasn't meant to be." They said that!

These are the words of a woman who had experienced the stillbirth of her first child. Until recently, the experience of stillbirth was not well understood. It was assumed that since the mother did not have a chance to develop a postnatal relationship with her child that the mother would not grieve for her child (Deutsch, 1945). It was common following stillbirth for a woman to receive advice to quickly become pregnant again to replace the child that was lost (Bourne, 1968; Forrest, Standish, & Baum, 1982; LaRoche et al., 1984; Rowe, Clyman, Green, Mikkelson, Haight, & Ataide, 1978; Wolff, Nielson, & Schiller, 1970).

A quarter century ago investigators became interested in the relationship which develops between a mother and her live newborn infant. Research focused on whether or not there was a critical period postpartum when a bond is formed between a mother and her child (Ali & Lowry, 1981; Dunn, 1981; Hales, Lozoff, Sosa, & Kennell, 1977; Klaus, Jerauld, Kreger, McAlpine, Steffa, & Kennell, 1972: Klaus & Kennell, 1976). In expanding on the investigation of postnatal attaching, researchers began to investigate whether or not attaching began in the antenatal period (Cranley, 1981a; Lumley, 1980a, 1982; Rubin, 1975, 1984; Stainton, 1985a). In an attempt to understand antenatal attaching, investigators studied women who had experienced a stillbirth to determine if they were attached to their stillborn child (Kennell, Slyter, & Klaus, 1970; Kirkley-Best, 1981). As these mothers did not have an opportunity to know the live child postnatally, evidence that there was attachment to the child gave credence to the theory that attaching is a process which begins in the antenatal period. It appears ironic that the investigation of attaching behaviour in women who have had a stillbirth was initially motivated not by a need to help these women with their grieving, but rather to understand better the experience of women who give birth to live children. However, these studies did increase awareness that women who experience a stillbirth have been in the process of attaching to their child and that the loss is significant to them. The grief reaction of women to stillbirth has, in recent years, been well documented (Bourne, 1983; Clark & Williams, 1979; Dunlop, 1979; Furlong & Hobbins, 1983; Kirk, 1984; Kowalski & Bowes, 1976; Stringham, Riley, & Ross, 1982; Wolff, Nielson, & Schiller, 1970).

"Once bitten, twice shy". This old saying has possible relevance for women who have experienced a stillbirth. What effect does having had a stillbirth have on the relationship of a woman with the next child she conceives? A limited amount of literature suggests that the previous death of a child may influence the mother's relationship with a child born subsequently, as the mother may either become overprotective of the child or fail to develop a nurturing relationship with the child (Bourne & Lewis, 1984b; Cain & Cain, 1964; Floyd, 1981; Lewis, 1979a; MacCarthy, 1969; Pozanski, 1972, Green & Solnit, 1964).

No literature was found investigating the process of attaching prospectively in women who have had a stillbirth and are pregnant again. Therefore, in this research study, grounded theory method (Glaser & Strauss, 1967) was used to investigate the process of livebirth following stillbirth from the mother's perspective and to generate a tentative theory describing this process.

Purpose of the Study

The purpose of the study was to identify and describe the perinatal maternal processes that occur with livebirth following stillbirth.

Research Questions

The research questions that guided this study were: How do mothers who have previously had a stillbirth describe the process of coming to know their infant? a) How do pregnant women who have previously had a stillbirth describe their interactions with their unborn children? b) How do mothers who have previously had a stillbirth describe their interactions with their neonates following birth? c) How do mothers who have previously had a stillbirth describe their interactions with their infants at one month postpartum?

Definition of Terms

Attachment: As this was an emic study designed to investigate the maternal processes in livebirth following stillbirth, a definition of attachment arose from the informants' description of the process rather than being predetermined. Further discussion regarding the informants' perception of attachment is found in the Discussion and Implications chapter. Definitions of attachment found in the literature are included in the Literature Review chapter.

Stillbirth: For the purposes of this study, stillbirth was defined as a fetal death following 20 or more weeks gestation. Both intrauterine fetal deaths which occurred in labour and intrauterine fetal deaths which occurred prior to labour were included in this study.

Significance of the Study

It is common when recording a nursing history to document the gravidity and parity of a woman. Nurses are often aware that a woman has previously had a stillbirth, but knowledge of the effect of the stillbirth on the woman's relationship with the child in the subsequent pregnancy is not known. The findings of this study contribute to nursing knowledge by providing a tentative theory of the maternal processes in a pregnancy following stillbirth. This theory can be used by perinatal nurses in assessing, planning and implementing appropriate nursing care to facilitate the relationship between mothers and their infants born following perinatal loss. Implications for nursing practice are presented in detail in the Discussion and Implications chapter.

CHAPTER II

LITERATURE REVIEW

Deutsch (1945) was one of the first authors to theoretically consider maternal-infant attaching behaviour associated with the experience of women and perinatal loss. She minimized the effect of perinatal loss on women by concluding that since a woman has no opportunity to interact with her stillborn child, the loss is of minimal importance to her. With the recent research which indicates that attaching to the infant begins before the child is born (Cranley, 1981a; Lumley, 1980a, 1982; Rubin, 1975; Stainton, 1985a) health professionals have become aware of the grief a perinatal loss may cause (Hutti, 1984; Kirkley-Best & Kellner, 1981). While studies have recognized the devastation which occurs when the relationship between a mother and her unborn child ends in stillbirth, few research studies have been designed to investigate the effect that the experience of stillbirth has on the relationship between the mother and her child in a subsequent pregnancy (Phipps, 1985).

In this chapter the literature available on the processes of maternal-fetal attachment and maternal-infant attachment will be summarized, as will the literature describing the effect of perinatal loss and grieving on attaching behaviours.

Attaching Behaviour

The topic of human maternal-infant attachment received considerable attention in the early 1970's when it was hypothesized that there was a critical period immediately after birth during which time a bond was formed between a mother and her child (Kennell, Slyter, & Klaus, 1970; Klaus, Jerauld, Kreger, McAlpine, Steffa, & Kennell, 1972; Klaus & Kennell, 1976; Klaus, Kennell, Plumb, & Zuehike, 1970). The pioneering work by Kennell and Klaus precipitated many researchers to investigate the effects of both the quality and quantity of interaction between mothers and their newborn children in the postpartum period on attaching behaviours (Ali & Lowry, 1981; Curry, 1982; Dunn, 1981; Grossman, Thane, & Grossman, 1981; Hales, Lozoff, Sosa, & Kennell, 1977; Klaus, Jerauld, Kreger, McAlpine, Steffa, & Kennell, 1972; Klaus & Kennell, 1976; Kontos, 1978; Leifer, Leiderman, Barnett, & Williams, 1972; O'Connor, Sherrod, Sandler, & Vietze, 1978; Siegel, Bauman, Schaefer, Saunders, & Ingram, 1980). Initially emphasis was placed on a critical period for attaching to occur. This notion has since been questioned (Elliot, 1983; Nelson, 1985; Stainton, 1986; Tulman, 1981). Criticisms of the research have included inappropriate generalization from animal studies, non-replication of study findings, preexisting differences among experimental groups, inadequate sample size, inconclusive evidence that the independent variables measured were actually indicative of maternal-infant attachment, and failure to account for the role of individual differences in mothers and infants (Chess & Thomas, 1982; Goldberg, 1983; Herbert, Sluckin, & Sluckin, 1982; Lamb, 1982; Lamb & Hwang, 1982; Leiderman, 1978; Morgan, 1981, Myers, 1984).

Campbell and Taylor (1979) questioned whether attempts to measure maternal-infant attachment at points in time were true measures indicative of the attachment process over time. Through the extensive research on maternal attachment it has been recognized that attaching is a process that occurs over time (Cranley, 1981a; Rubin, 1977; Stainton, 1985a, 1985b) and that it is initiated in the antenatal period (Rubin 1975, 1977; Stainton, 1985a).

The many studies on maternal-fetal and maternal-infant attachment have used a variety of terms to describe the relationship that develops between a mother and her child. Klaus and Kennell (1976) used the terms bonding and attachment interchangeably. Other authors defined bonding as the tie between the mother and her child which develops shortly after birth (Campbell & Taylor, 1979), while attachment has been defined as the bidirectional, long term, relationship developed between a mother and her child during the first year of life (Ainsworth, 1964, 1969; Bowlby, 1958; Campbell & Taylor, 1979). In this research study, no attempt was made to confine the literature review to any one particular definition of the relationship between a mother and her child. Rather, any pertinent literature that was identified reporting on maternal-fetal attachment and maternal-infant attachment was included.

Many of the research studies have focused on attempting to identify variables which are indicative of adaptive and maladaptive attaching behaviour. Although the research is incomplete as yet, studies have identified behaviour thought to be indicative of adaptive maternal-infant attaching (Cropley, Lester & Pennington, 1976; Klaus, Kennell, Plumb, & Zuehike, 1970; Robson & Moss, 1970; Rubin, 1961) and some factors that place a mother and child at risk for maladaptive maternal-infant attaching behaviour (Carek & Capelli, 1981; Clark & Affonso, 1976; Crittenden & Bonvillian, 1984; Frommer & O'Shea, 1973; Kennedy, 1973; Korner & Grobstein, 1967; Mercer, 1981b; Newton & Newton, 1962; Peterson & Mehl, 1978; Robson & Moss, 1970; Sugarman, 1977). This intense interest in identifying maladaptive maternal-infant attaching behaviour has been propagated by research that indicates a possible link between maladaptive maternal-infant attaching behaviour and subsequent child abuse and neglect (Egeland & Vaughn, 1981; Hunter, Kilstrom, Kraybill, & Loda, 1978; Klaus & Kennell, 1970; Lynch & Roberts, 1977).

As a result of the proposed relationship between these factors, nursing care has been focused toward identifying mother-infant dyads at risk for maladaptive maternal-fetal and maternal-infant attaching behaviour (Josten, 1981). One of the concerns with the studies attempting to identify factors that indicate adaptive and maladaptive attaching behaviour is whether or not the variables measured are valid indicators of the interaction process between the mother and her child.

Cropley, Lester and Pennington (1976) were one of the first groups of researchers to develop a tool to be used by nursing staff for measuring maternal attachment behaviour in the neonatal period. The authors did not report on the reliability and validity of their tool. Cranley (1981b) developed a tool to measure maternal-fetal attachment with reported reliability and validity. Tools with reported reliability and validity have also been developed to measure postnatal maternal-infant attachment (Funke-Ferber, 1978; Stainton, 1981). The tool developed by Funke-Ferber (1978) also measured maternal-fetal attachment.

A number of studies have investigated the effectiveness of nursing interventions to facilitate maternal-fetal attachment (Carson & Virden, 1984; Carter-Jessop, 1981; Croft, 1982; Grace, 1984). In a review of these four studies, Gaffney (1988) noted the conflicting findings and concluded that the effectiveness of nursing interventions to promote maternal fetal attachment was inconclusive.

A number of descriptive articles in the literature report on nursing interventions to facilitate maternal-infant attachment (Dean, Morgan, & Towle, 1982; Gay, 1981; Jenkins & Tock, 1986; Reiser, 1981; Rhone, 1980). In addition, research based studies have demonstrated that teaching mothers about newborn behaviour facilitates maternal-infant attachment (Davidson, Williams, Painter, & Joy, 1981; Furr & Kirgis, 1982; Stainton, 1981).

Further research studies have investigated the relationship between antenatal maternal-fetal attachment and postnatal maternal-infant attachment. Cranley (1981b) found no relationship between levels of prenatal maternal attachment as measured by the Maternal Fetal Attachment Tool, and postnatal attachment to the child as measured by the Neonatal Perception Inventory. Findings of a study by Hauck (1985), indicated that prenatal attachment measured by an instrument developed by Hauck and administered in the last month of pregnancy was a good predictor of postnatal attachment, accounting for 37 percent of the variance. Lumley (1982) reported that early attachment to the fetus did predict both early attachment to the infant after birth and early development of maternal self confidence in caring for the infant.

No relationship has been found between demographic variables such as age, socioeconomic status, parity, or education, and antenatal maternal-fetal attachment (Cranley, 1981b; Kemp & Page, 1987). The relationship between anxiety and attachment behaviour is inconclusive. Cranley (1981b) reported that "Women who perceived themselves as having more stress during their pregnancies had lower scores on the Maternal Fetal Attachment Scale" (p. 284). Similarly, Gaffney (1986) reported decreased prenatal attachment scores with anxiety. Avant (1981) reported that highly anxious mothers had low attachment scores postnatally. Boudreaux (1981) and Penticuff (1982) also supported the hypothesis that the anxiety associated with high risk pregnancy causes a resistance to attaching as the mother fears that something untoward might happen to her unborn child. Kemp & Page (1987) reported no significant differences in the scores of normal and high risk women on prenatal attachment as did Mercer, Ferketich, May, DeJoseph and Sollid (1988).

Antenatal Maternal-Fetal Attachment Behaviour

A number of behaviours have been identified in the literature as occurring in the process of forming a relationship between the mother and child antenatally. The first is where the mother differentiates the unborn child as being a separate individual from herself (Bibring, Dwyer, Huntington, 1961; Cranley, 1981b; Kennell & Klaus, 1971; Leifer, 1977; Rubin, 1975; Tanner, 1969). A second behaviour identified in the antenatal attachment process is that some women interact with their unborn child by talking to the child and by touching the child through their abdomen (Carter-Jessop, 1981; Cranley, 1981b, Leifer, 1977; Rubin, 1975; Stainton, 1985a). A third behaviour of interaction with the unborn child which some mothers undertake is the mother assigning characteristics to her unborn child such as identifying the sex of the fetus, identifying physical characteristics such as hair colour, and identifying personality traits of the fetus (Cranley, 1981b; Stainton, 1985a). A fourth behaviour is maternal nesting behaviour; the actions a mother goes through to physically prepare for the child such as preparing a nursery (Cranley, 1981b; Leifer, 1977; Tanner, 1969). A fifth behaviour of antenatal mother-fetal attachment described in the literature is the mother fantasizing about the mothering role; she imagines herself caring for the child, playing with the child, etc. (Cranley, 1981b; Rubin, 1967, 1970, 1972).

In a classic article written by Rubin in 1975, four antenatal tasks of pregnancy were identified: 1) the mother seeks safe passage by protecting the wellbeing of her unborn child (seeking prenatal care and prenatal information), 2) the mother seeks acceptance of the expected child by significant others, 3) the mother gives of herself to the unborn child (by such actions as eating nutritiously and avoiding harmful substances), and 4) the mother binds-in to her unborn child. While in the first trimester the mother binds-in to the idea of the pregnancy itself, the bond to the child increases in the second trimester with the occurrence of quickening. Other authors have reported that quickening facilitates attaching antenatally (Lumley, 1980a, 1980b; Taylor & Hall, 1979, Tanner, 1969). A final maternal antenatal task identified in the literature, is preparing to give up the unborn child in the third trimester (Rubin, 1975, Tanner, 1969).

Building on the work of Rubin (1975), Vito (1986) explicated the time frame for antenatal attaching as being as follows; binding-in to the pregnancy occurring in the first 18 weeks gestation, binding-in to the fetus occurring between 18 and 26 weeks gestation, and binding-in to the child occurring beyond 26 weeks gestation. Lumley (1980b) hypothesized that previous nurturing predisposes women to view the fetus as a person earlier in pregnancy, therefore, it is possible that attaching begins earlier in multiparous women. In a phenomenological study, Bergum (1989) described in detail how the presence of the unborn child transforms a woman to a mother. These studies collectively provide a description of the process of how a mother incorporates the unborn child growing inside her with the expectation of mothering a child.

Cohen (1966, 1979) identified failure to achieve the developmental milestones of pregnancy as maladaptive and that adverse prior experience in childbearing is a predisposing factor. He acknowledged that perception by the mother of a threat to the wellbeing of her unborn child might seriously compromise her ability to accomplish the tasks of pregnancy. Cohen recommended additional follow-up where there is failure to develop attachment to the fetus following quickening, absence of nesting behaviour, or absence of fantasies of what the unborn child is like or what the baby will be like. Tanner (1969) reported that failure to achieve the tasks of pregnancy may result in the mother not being ready to establish a caretaking relationship with the newborn infant. Similarly, Raphael-Leff (1982) linked failure to accomplish the tasks of pregnancy with distortions in the postnatal interaction with the infant. She recognized an unmourned previous stillbirth as being a risk factor.

Rubin (1984) described the fear that a gravid women has during pregnancy that something untoward could happen to her unborn child. Rubin reported that the fear of something happening increases toward term and that mothers say the sex of the baby is unimportant as long as the child is healthy. Multiparas have increased knowledge of what can go wrong. Rubin described how women dread having an imperfect child and therefore fear delivery. They would prefer to avoid labour and delivery if that was possible and women who expect an imperfect child hold back in labour. Rubin described the relief that women feel after delivery but that they must verify the child's wellbeing themselves: "Confirmation of the baby's good condition by others affords welcome objectivity and reality testing, but there continues to be an ongoing, independent verification of the baby's condition by the mother herself" (p. 133).

Postnatal Maternal-Infant Attaching Behaviour

In attempting to study maternal-infant attaching behaviour postnatally, a number of maternal behaviours have been used as indicators of attachment. The maternal attaching behaviours seen postnatally seem to follow from the antenatal indicators of attachment. While during pregnancy the mother attempts to differentiate the unborn child from herself, postnatally the mother must work to accept the separating-out process (Rubin, 1977), come to recognize and accept the neonate as being hers (Gottlieb, 1978; Robson & Moss, 1970, Rubin, 1961, 1977) and differentiate and accept the actual newborn from the fantasized child (Mercer, 1981a; Rubin, 1972). Gottlieb (1978) identified the steps in the process of a mother accepting her newborn infant as being (1) identifying unique physical characteristics and actions of the infant (2) relating and identifying the infant's behaviour to a familiar event, person, object, or fantasized child, and (3) interpreting the baby's actions by giving meaning to them. Important in the acceptance of the child is the mother's perception that the child is normal. Rubin (1961) identified a compulsive need for mothers to ascertain that the baby is whole and intact and Chao (1979) identified a mother's concern with her child's ability to function.

Observation of maternal infant interaction can also reveal attachment. The following are suggested as indicating attachment: the progressive nature of touching the child (Cannon, 1977; Klaus, Kennell, Plumb, & Zuehike, 1970: Rubin, 1963), holding the child in the "en face" position, and maintaining eye contact (Robson, 1967; Stainton, 1986). Postnatal maternal care taking skills can be observed directly in the postnatal period as a measure of maternal attachment (Barnett, Leiderman, Grobstein, & Klaus, 1970; Klaus & Kennell, 1970; Rubin, 1963).

While the postnatal behaviours described have been used to directly evaluate maternal-infant attachment, these measures fail to consider the mother's perception of her relationship with her infant. The postnatal maternal behaviours are explicit indicators of maternal-infant attachment, however, they do not contribute to the implicit understanding of the social interaction process between a mother and her newborn child.

One of the additional tasks of accepting a child in the postpartum period that has been identified in the literature is the task of encompassing the new role of mother and letting go of former incompatible roles. This has particular significance for the multigravida accepting her second child. Rubin (1975) labelled this process "grief work":

> Grief work is a review, in memory, of the attachments and associated events of a former self (role). The experiences, interpersonal and situational, associated with the former self include the actual and the hoped for, the pleasant and the unpleasant. The review in memory of the

> details of the former-self serves to loosen the ties with the former self. ... With the second child, the scope of roles reviewed in grief work was the same as it was with the first child with the addition of the review and tentative detachment from the experiences with the first child. (p. 243-244).

Walz and Rich (1983) also described the process of grieving in multiparas as the maternal task of resolving the loss of an exclusive dyadic relationship with the first child. They advocated that this is accomplished by the mother reviewing and comparing the psychological and physical characteristics of the first child and her relationship with that child to the new child.

Perinatal Loss and Attaching Behaviour

Lindemann (1944) was one of the first to document the stages of grief following a loss, however, it was with the publication on death and dying by Kubler-Ross in 1969 that knowledge of the process of grief became widely known. The five stages of grief reported by Kubler-Ross are denial, anger, bargaining, depression and acceptance. Although it is known that grief over the loss of a loved one is never completely resolved (McCollum & Schwartz, 1972), acceptance of the loss and resolution of the acute stage of grief is thought usually to occur about 12 months after the loss (Engel, 1964; Parkes, 1972; Helmrath & Steinitz, 1978). It has been recognized that acceptance of the loss and resolution of the grief are important components in being able to develop new relationships (Bowlby, 1980; Lindemann, 1944; Parkes, 1970a, 1972). The grieving person must accept that the loved person no longer exists. This permits withdrawal of intense emotion and feeling from the relationship and gives the person the freedom to psychologically invest in new relationships (Gardner & Merenstein, 1986a).

The devastation and grief caused by stillbirth has been well documented in the literature (Bourne, 1968, 1983; Bruce, 1962; Clark & Williams, 1979; Dunlop, 1979; Furlong & Hobbins, 1983; Giles, 1970; Harris, 1984; Jensen & Zahourek, 1972; Kirk, 1984; Kowalski & Bowes, 1976; LaRoche et al., 1984; Lovell, 1983b; Outerbridge, Chance, Beaudry, MacMurray, Pendray, & Shea, 1983; Panuthos & Romeo, 1984; Peppers & Knapp, 1980b, Phipps, 1981; Saylor, 1977; Stringham, Riley, & Ross, 1982; Wolff, Nielson, & Schiller, 1970; Zahourek & Jensen, 1973). With the occurrence of stillbirth, the dream of the wished for child is thwarted (Davidson, 1977, Kennell & Trause, 1978) as is the goal of becoming a mother to a child (Friedman & Gradstein, 1982). The mother who has begun the process of attaching to her unborn child must embark on the process of detaching from the stillborn child and accepting the loss (Kirkley-Best & Kellner, 1982). Peppers and Knapp (1980a, 1980b) reported that grief reactions are the same following all types of perinatal loss. Graham, Thompson, Estrada, and Yonekura

(1987) reported that women who already had children were less depressed following stillbirth than were women with no children. Kirkley-Best and Kellner (1982) observed that there is no difference in the grieving process which occurs following the occurrence of stillbirth during labour and the grieving process which occurs following the occurrence of intrauterine fetal death prior to labour.

It is recognized that mourning a stillbirth is a rather unique process as compared to the mourning which occurs following the death of an adult or older child. Mourning involves taking in the reality of the loss. With stillbirth, there is a degree of unreality surrounding the loss (Bourne, 1968; Lewis, 1976). One of the obstacles to mourning is the mother's lack of experience with the child being alive postnatally (Harrington, 1982; Lewis & Page, 1978). Normally, memories of the dead person facilitate mourning but with a stillborn infant, memories are limited and the mother is often restricted in the people she can talk to about the baby (Lewis & Page, 1978). Many authors have recognized the importance of assisting grieving parents in recognizing the reality of the stillborn infant and advocate such interventions as encouraging the parents to hold their stillborn child, name the child, have a memorial service for the child, and retain pictures of the stillborn child (Cohen, Zilka, Middleton & O'Donnohue, 1978; Gardner & Merenstein, 1986b; Harrington, 1982; Kirkley-Best & Kellner, 1982; Lovell, 1983a).

A principal component in the reaction to loss is yearning and searching for the lost object and the urge to recover the lost object (Bowlby, 1961; Parkes, 1970b). One of the responses to stillbirth is an intense desire to become pregnant to replace the child who was lost and to avoid the pain accompanying the loss (Lewis & Page, 1978). Fifty percent of women who had a stillbirth are pregnant again within two to three years (Bourne, 1968; Fedrick & Adelstein, 1973; Forrest, Standish, & Baum, 1982; LaRoche et al., 1984; Rowe, Clyman, Green, Mikkelson, Haight, & Ataide, 1978; Wolff, Nielson, & Schiller, 1970).

The pregnancy that occurs following a stillbirth raises a number of issues that have been addressed in the literature. First is the effect of subsequent pregnancy on mourning the stillborn child. It has been recognized that pregnancy interrupts the mourning process (Bourne & Lewis, 1984a, 1984b; Lewis, 1979b; Lewis & Page, 1978; Elliot & Hein, 1978). The parents may not allow themselves to experience the impact and intensity of the response to their loss (Garland, 1986; Turco, 1981), but rather attempt to alleviate the grief they feel by embarking on another pregnancy. Lindemann (1944) recognized the existence of delayed grief: postponement of the mourning process until a later time at which point renewal of the grieving process might proceed normally or be distorted.

Second, the subsequent pregnancy may result in the mother fusing the stillborn child and the unborn child in the next pregnancy. Harris (1984) reported that grieving for the stillborn child involves idealizing what the dream baby would have been like and projecting to what the future experience might have been. With the occurrence of the subsequent pregnancy these tasks of grieving are interrupted by the existence of the unborn child (Lewis, 1980; Lewis & Page, 1978; Seitz & Warrick, 1974). Several authors have identified the importance of assisting the mothers to differentiate between the two children (Kirk, 1984; LaRoche et al., 1984; Lewis & Page, 1978; Richardson, 1974; Seitz & Warrick, 1974; Taylor & Hall, 1979). Differentiation is thought to facilitate mourning and acceptance of the loss rather than avoidance of it (LaRoche et al., 1984).

Third, the birth of a child following perinatal loss has been linked with possible maladaptation in parenting in three ways: (1) unresolved grief contributing to maladaptation (2) fear of recurrence of the loss contributing to maladaptation, and (3) simultaneously detaching from the lost child while attaching to the live child contributing to maladaptation .

Few research based studies which document a link between subsequent pregnancy following a perinatal loss and difficulties in mothering the live child have been identified. Many authors have empirically described a possible link between unresolved grief in subsequent pregnancy resulting in mothering difficulties (Bourne & Lewis, 1984b; Cropley, Lester, & Pennington, 1976; Floyd, 1981; Harrington, 1982; Klaus & Kennell, 1976; Klaus & Fanaroff, 1979; Lewis & Page, 1978; LaRoche et al, 1984; MacCarthy, 1969). In a study which measured maternal-infant attachment postnatally, Stainton (1981) reported that mothers who had previously lost a child had lower attachment scores compared to mothers who had not experienced a loss. Lewis (1976, 1979a, 1979b, 1979c), based on a number of case studies, has linked failure to mourn a stillbirth with subsequent child abuse.

Many authors have given theoretical accounts and published case studies describing the interaction between parents and a child born following the death of another child (Bourne & Lewis, 1984a; Cain & Cain, 1964; Floyd, 1981; MacCarthy, 1969; Pozanski, 1972; Richardson, 1974). These authors report that a previous loss negatively influences the relationship between the subsequent child and the parents. They suggest that parents are afraid that the replacement child will die as well, and respond by either failing to attach to the child or by becoming overprotective.

> Fear of recurrence is particularly strong in the months after death, the mother cannot trust her new baby to live, and so refuses to accept his existence until he is born. However, this allows no time for the psychological preparation necessary for the acceptance of a new member of

> the family, and may thus mar mother-child relations (Harrington, 1982, p.26).

Penticuff (1982) recognized that high risk women must work through the threat to the pregnancy otherwise the threat inhibits development of the feeling of maternal adequacy. Green and Solnit (1964) used the term "vulnerable child syndrome" to describe the overprotective behaviour that parents engage in when they anticipate the loss of a child. One of the predisposing factors to the development of vulnerable child syndrome identified was an unresolved grief reaction related to the death of another child. Lewis (1983) reported a relationship between maternal anxiety and the development of emotional insecurity in children born subsequently to the death of a sibling by sudden infant death syndrome.

Several authors described the difficulty involved in detaching from the dead child while at the same time attaching to a new child (Bourne & Lewis, 1984b; Helmrath & Steinitz, 1978; Kennell & Trause, 1978). Other authors have similarly described the difficulty in grieving the loss of a perfect child and attaching to a defective child (Solnit & Stark, 1961). Forrest, Standish and Baum (1982) reported that women who waited longer than a year before conceiving coped better and had fewer mothering problems in the subsequent pregnancy than women who conceived earlier.

Grief is known to be rekindled with the calendar anniversary of the loss (Cavenar, Spaulding, and Hammett, 1976; Musaph, 1973). It is not uncommon in pregnancy following stillbirth for the expected date of confinement to concur with the anniversary date of the loss (Bourne & Lewis, 1984b). In pregnancy following a perinatal loss, the gestational age anniversary of the loss is also significant. Bodnar (1985) reported delay in development of attaching behaviour in a pregnancy following a miscarriage, until the gestational age at which the miscarriage occurred in the previous pregnancy was past. Similarly Cornwell, Nurcombe and Stevens,(1977) observed that parents who previously lost a child to sudden infant death syndrome developed more confidence with a child born subsequently when the child was past the age at which the previous loss occurred. Richardson (1974) reported that the anniversary of the loss helped a mother to differentiate the lost child from the live unborn child.

The presence of anxiety in the pregnancy following a perinatal loss has been recognized (Lewis, 1980; Seitz & Warrick, 1974). It is known to decrease to a degree once the gestational age at which the previous loss occurred is past (LaFerla & Good, 1985) and to increase again in anticipation of labour and delivery (Kowalski, 1980). One of the factors contributing to the anxiety is fear that perinatal loss will occur again (Borg & Lasker, 1981; Cordell & Apolito, 1981;

Gardner & Merenstein, 1986a, Hagan, 1974; Harrington, 1982; Jolly , 1976; Kowalski, 1980). Fear of recurrence is also seen following miscarriage (Swanson-Kauffman, 1986), and following sudden infant death syndrome (Mandell & Wolfe, 1975). In the postpartum period, fear that something untoward will happen to the child is increased if the child is ill (Lewis, 1980). Although a parent's fear of recurrence may be based on the trauma of the experience of stillbirth, there is actually an increased risk of subsequent mortality following the occurrence of stillbirth (Freeman, Dorchester, Anderson, & Garite, 1985; Newcombe, 1968). As previously discussed, one of the factors which may contribute to impeding the attachment process in a pregnancy following a loss is this fear that another loss will occur.

It is recognized in the literature that the birth of a live child rekindles the mourning for the child that is lost (Bourne & Lewis, 1984b; Harrington, 1982; Kowalski, 1980; Seitz & Warrick, 1974; Taylor & Hall, 1979). Completing the mourning process for the dead child has been suggested as an important step prior to assuming a healthy relationship with the live child (Seitz & Warrick, 1974), however, this has not been researched previously.

Subsequent Pregnancy Following Stillbirth

Despite the vast amount of literature that provides fragments of information regarding the experience of subsequent pregnancy following stillbirth, few articles are available documenting research that was designed to investigate this experience. In this literature review the researcher has attempted to provide an overview of the literature that addresses aspects of the process involved as a mother develops the relationship with her child following stillbirth.

Kirksey (1987) wrote a chapter describing the experience of women in post-stillbirth pregnancy but the information presented was not referenced to research studies. Only two research based studies were found which documented the experience of pregnancy following stillbirth.

A study by Wilson, Soule and Fenton (1988) examined the responses of parents who had an infant subsequent to a stillbirth. Eight couples who had a stillbirth were interviewed two years following the birth of their subsequent child as were eight couples who had previously delivered a live child. Two of the couples had experienced the stillbirth in their first pregnancy and the six others were multiparas when the stillbirth occurred. The couples who had previously had a stillbirth had conceived on average 10 months following the stillbirth. In the interviews, the couples who had previously had a stillbirth reported increased anxiety in the subsequent pregnancy. They feared that this child too would die. They did not prepare for the new baby during the pregnancy. In the intrapartum period, they wanted the nursing and medical staff to acknowledge their previous loss and they wanted to hold their baby more than the control group.

The study by Phipps (1985) was designed as a preliminary exploration into the nature of the stresses produced by subsequent pregnancy after stillbirth and how parents deal with those stresses. Fifteen couples were interviewed. Eight couples had previously had a stillbirth and seven couples had previously had a neonatal death. The mean age of the child born subsequently when the interviews were conducted was 15 months. Using grounded theory method to analyze the data obtained through interviewing, Phipps reported that the mothers were extremely anxious during the pregnancy and that there was a "suspension of commitment to the pregnancy" (p. 248). Adaptation to parenthood following delivery of the child was not impaired, however, anxiety regarding the child's health continued for several months postpartum.

One of the major limitations of these two studies on post-stillbirth pregnancy is that they were conducted retrospectively once the children born subsequently were well over one year of age. No research was found which investigated the experience of women as they progressed through the subsequent pregnancy and developed the relationship with their unborn child and the liveborn child after birth. Others have identified the lack of information in this area: "A fruitful area for further investigation would be direct observation of mother infant interaction when mothers become pregnant shortly after the death of their baby" (LaRoche et al., 1984, p. 18). Hutti (1984) who examined the literature available on perinatal death, in reporting implications for nursing practice and research, recommended studying the effect of anticipatory grief to determine the effect this has on later attachment if perinatal death does not occur. Stainton (1981) identified the need for further study of attaching behaviour in women who have lost a child previously.

This literature review indicates that there is a void in the knowledge of the process of attachment in women who have previously had a stillbirth to the unborn child in a subsequent pregnancy and live child following birth. It is evident that there is a need to study these women more closely to determine their experience during pregnancy following stillbirth.

Chapter III

METHOD

The purpose of this research was to identify and describe the perinatal maternal processes that occur with livebirth subsequent to stillbirth. As evident from a review of the literature, these processes have not been explored earlier. Grounded theory (Glaser & Strauss, 1967) is a research method used to generate theory in areas that have not been investigated previously, therefore, it was chosen as the method for this study.

Grounded theory is an inductive method. The theory is derived from studying and analyzing the behaviourial patterns of the informants (Glaser, 1978). Grounded theory is guided by the assumption that people do order and make sense of their environment (Hutchinson, 1986). For this study, it was assumed that there would be a common experience shared by women who become pregnant following a stillbirth. Developing a beginning understanding of this experiential process was sought.

The Sample

A purposive sampling method was used, with informants being specifically selected because of the contribution they could make toward an understanding of the process of attaching to an unborn child and an infant following stillbirth. Since obtaining relevant data was essential, this non-random selection of informants was important to facilitate the quality of the information obtained (LeCompte & Goetz, 1982).

The eleven informants were selected using a number of methods. Initially, informants were sought from within the practises of obstetricians practising in one health care facility. As this method yielded few informants, the research proposal was modified to expand the process for seeking informants. A letter and the study abstract were sent to 35 obstetricians in the local area. The letter explained the study and requested that the physicians review their charts to see if any of their clients met the informant selection criteria. The obstetricians were asked to inform suitable clients of the study and ask if they would be willing to discuss the research with the investigator. Each obstetrician was provided with a flyer describing the study that could be posted in the office. Two weeks after sending the letters, each physician's office was contacted by telephone. One informant who met the criteria was found through this approach.

Four obstetricians were contacted in person, resulting in the referral of three of the informants. One informant was referred through a friend. Advertisements were placed in three of the local newspapers at various times over a period of three months. Of the fifteen woman who responded to the newspaper advertising, six met the criteria and participated in the study. One woman who responded to the advertising had experienced the stillbirth of a child 30 years earlier and wanted reassurance that she was not abnormal because she still grieved the loss of that child. Further advertising was done through the university campus newspaper and through flyers sent to community service prenatal classes, however, no informants were found through these methods.

The number of informants needed to participate in the study was not predetermined. Sampling continued until all the major variables that had been identified during data analysis were explored and no new information was being obtained. Theoretical sampling was used to expand the informant selection criteria to include informants who could contribute valuable information. As a consequence of theoretical sampling, three informant groups were developed: the primary informants, the alternate informants, and the secondary informants. Eleven informants participated in the study (See Appendix A for Informant Groups).

Primary Informants:

The criteria for selection of the primary informants were as follows: (1) speak and read English (2) married or have a stable relationship with the father (3) in the last trimester of pregnancy (4) stillbirth in the previous pregnancy (5) 21 years of age or older (6) resident of the Metro area (7) be willing to participate in a minimum of three interviews. Four primary informants participated in the study. All primary informants had a stillbirth in their first pregnancy and were in the last trimester of their second pregnancy when first interviewed. These four informants, therefore, had no experience in mothering a live child.

Alternate Informants:

The alternate informants were women who did not meet the primary informant selection criteria but were women whose contribution to the data could further expand the information obtained and the theory generated. Five women were interviewed as alternate informants. The alternate informants were interviewed in the second trimester of pregnancy in order to verify the recalled data provided by primary informants and to investigate further the influence of gestational age on the process of livebirth following stillbirth. Although the alternate informants had a perinatal loss in their first pregnancy, three of the informants had successfully delivered a live child since the loss. These women were also included to investigate the influence of having been successful in the mothering role on the process of livebirth following stillbirth. Two of the alternate informants had experienced a neonatal death rather than a stillbirth. One of the infants died at four days of age, however, the mother did not have any contact with the infant in the neonatal period. In the second case, the infant died at eight days of age. Maternal contact with the infant was minimal as the mother was post-operative from a cesarean delivery and the infant was transported to a different hospital for intensive neonatal care. It is interesting to note that it was only during the interviewing that the researcher determined that these two informants had had a neonatal death rather than a stillbirth. The women called their loss a stillbirth, and did not themselves differentiate the type of loss.

Secondary Informants:

Two woman acted as secondary informants in verifying the theory developed regarding livebirth following stillbirth. One of these informants was located too late to be included in the initial data collection but was able to be included as a secondary informant by the time the theory was ready for verification. The second informant was a woman who had experienced a stillbirth 31 years previously. She was selected both to contribute to identifying the effect of time on the process and to verify the process.

Demographic Information:

A summary of the demographic information is included in Appendix B. The informants ranged in age from 23 to 39 years. Two of the informants were of Chinese descent, one being a first generation Canadian while the other was a second generation Canadian. Another informant had emigrated from Europe.

The highest level of education completed by the informants varied: four informants had completed university courses, three had college diplomas, two had completed high school, one completed junior high and one completed grade school.

Ten of the informants were married. One of the alternate informants was not married and had separated from her common law husband since becoming pregnant.

Of the 10 women who were interviewed during pregnancy, four continued to work, one was unemployed, two were full time students, and three had previously worked but chose not to while pregnant.

The annual family income of the informants varied with three informants having incomes between $5000 and $10,000 , five having incomes between $20,000 and $50,000, and three having incomes greater than $50,000.

Of the nine informants who had a stillbirth, three were caused by cord accidents, three were a consequence of pregnancy induced hypertension, two were caused by congenital anomalies, and one was of unknown origin. For the two neonatal deaths, one was caused by premature rupture of membranes and the other was caused by hypoxemia. For one woman the stillbirth occurred at 20 weeks gestation, another woman was at 26 weeks gestation, three women were at 28 weeks gestation and three were at term. Three of the woman were diagnosed as having an intrauterine fetal death prior to labour, while for the other six women the fetus died during labour. (See Appendix C for Characteristics of the

Perinatal Loss).

One of the alternate informants was expecting twins when interviewed for the study. One of the primary informants had delivered stillborn twins.

Three of the informants were pregnant within three months of their perinatal loss. Another five were pregnant by six months. Another informant was pregnant a year following the loss. Two of the informants became pregnant two years following the loss. Of these two women, one reported that she delayed pregnancy in order to recover both physically and emotionally from the loss and the other woman reported that she was in a common law relationship that was not stable.

The five alternate informants and the secondary informant who was pregnant were interviewed only antenatally, therefore, the outcomes of their pregnancies are unknown to the researcher. The four primary informants all delivered healthy infants and all delivered vaginally. All four women had labour induced prior to 40 weeks gestation. Two had labour induced at 37 weeks gestation, one was at 38 weeks gestation, and one was at 39 weeks gestation. Two of the woman delivered a live child of the same sex as the stillborn child, while the other two women had a live child of the opposite sex.

Data Collection

A total of 18 interviews were conducted. The alternate informants were interviewed one time only, as were the secondary informants. Three of the primary informants were interviewed three times, and one of the primary informants was interviewed twice.

The primary informants were interviewed during the last two weeks of pregnancy, in the first two weeks postpartum, and between four and six weeks postpartum. (See Appendix D for the Interview Schedule). The earliest that an alternate informant was interviewed was at 23 weeks gestation and the latest that a primary informant was interviewed was six weeks postpartum. The timing of the interviews was chosen to provide data that reflected the process of livebirth following stillbirth as it occurred over time.

The interviews were tape recorded and were transcribed by the researcher in less than 48 hours following the interviews. Following each interview and telephone conversation, the researcher recorded in a notebook field notes regarding the interview. The field notes reflected the researcher's thoughts and interpretations of the interview, as well as descriptive information about the setting, appearance, and observed behaviour of the informants. Demographic information was collected from the informants (See Appendix E for Demographic Data Sheet).

In attempting to obtain the informant's uninhibited perspective of their experience during the pregnancy following stillbirth, the researcher requested that informants be alone at the time of the interview. Interviews were scheduled at the mothers' convenience; at all but one interview, the husband was at work. At the interview where the husband was at home he discreetly left the room while the interview was conducted. For the informants who had live children, the interviews were conducted while the children had their naps or were in school.

The interviews were informal; nearly all involved drinking tea or coffee which contributed to the informality. Informants were free to discuss what they wished regarding the previous pregnancy and the current pregnancy. All but one informant spoke spontaneously about the previous perinatal loss. Guiding questions were used to focus the interviews when necessary (See Appendix F). The investigator made a conscious effort not to intervene in the conversation, but rather let the informants pause and then carry on to expand on their thoughts.

As the researcher progressed through the number of interviews and was in the process of analyzing the earlier interviews, more guiding questions were developed in order to clarify and verify data previously collected. The researcher tried to avoid predetermining what the informants wanted to discuss. The additional guiding questions were introduced only after the informants had spontaneously related their thoughts and feelings regarding their experience of livebirth following stillbirth.

Nine of the 11 women interviewed cried during the interviews. Although the informants were told that they could stop at any time if the memories were too painful, they all continued to talk about the child that they lost. The informants were willing to share their experience with the researcher. Being a nurse gave the researcher credibility in the eyes of the informants. They reported being pleased to have the opportunity to talk about their experience to someone who would understand. In addition, they hoped that their contribution might help other women who experience a stillbirth in the future. They also were interested to know how their experience compared with that of other women who were pregnant again following a stillbirth.

Between interviews, contact was maintained with the primary informants by telephone. This contact was important in order for the researcher to find out the date planned for delivery and to maintain contact in the six weeks following delivery. The additional contact helped develop a rapport between the researcher and study informants which created the potential for increasing the women's disclosure of intimate thoughts and feelings. If an informant disclosed information over the telephone that the researcher felt was pertinent to the research study, the researcher introduced the topic during the subsequent interview and was able to recapture the information.

The Setting

All but two of the interviews were conducted in the informants' homes. Interviews were held either in the living room or in the kitchen, whichever the informant preferred. It seemed that the familiar surroundings facilitated the informant's ability to relax and relay pertinent information. One of the informants lived 100 kilometres outside the city. The first interview with this informant was held in a conference room at the hospital when she came into the city for her antenatal appointment. The first postpartum interview was held in a parent teaching room on the postpartum unit, and the final interview was held in the informant's home.

Data Analysis

In grounded theory, data analysis begins with the initiation of data collection and is an ongoing process (Corbin, 1986a, 1986b; Fagerhaugh, 1986; Field & Morse, 1985; Glaser & Strauss, 1967; Stern, 1985; Stern, Allen, & Moxley, 1984). Data were collected over a period of five months. Following each interview the transcribed data were analyzed in detail by the investigator until the key concepts were identified. Each concept was given a code; a label that represented the concept. Each code was written at the top of an index card. On the front of the card the researcher wrote substantial memos describing the code. On the back of the card the researcher identified the sources of the code in various interviews. This was an important step in the data analysis as identifying the origin of codes permitted constant comparison of the data. Codes within an interview were compared, codes between interviews with the same informant were compared, and codes between interviews with different informants were compared. This process of constant comparison enabled the researcher to identify the antecedents and consequences of a code and the conditions surrounding a code. To assist with the ease of comparison, each code was identified by a colour and the code was highlighted in the transcripts by the appropriate colour.

Identifying the properties of each code facilitated sorting of the codes into categories. Memoing continued on a higher level; theoretically identifying relationships between the categories. Theoretical sampling, data collection and analysis continued until all of the major concepts that had been identified were explored and no new information regarding derived categories was obtained. The categories were sorted and delimited until the basic social psychological process of fearing recurrence was identified. When the steps in the process of livebirth following stillbirth and the core category had been identified, they were clarified and verified with the primary and secondary informants and revised as necessary.

Once the concepts in the process of livebirth following stillbirth were identified, the literature describing these concepts was reviewed. Combining the knowledge available from the literature with the process identified in the data resulted in the development of a beginning theory. The theory that was grounded in the data identified and described the maternal processes that occurred with livebirth following stillbirth.

Reliability and Validity

It was important that the theory developed truly represented the maternal processes that occurred. Validity refers to the extent that a research method actually observes or measures what it intends to observe or measure (Field & Morse, 1985). This is a strength of grounded theory method; the theory generated is "grounded" in the data collected. Confidence that the data obtained in this study was representative of reality is based on the following: (1) the informants were purposively selected for their knowledge and ability to share the knowledge (2) the interview technique elicited data from the informant's perspective (3) interviews and field notes were recorded in a non-experimental, natural setting (4) a number of interviews were conducted over time (5) through repeated interviews, theoretical sampling, and constant comparison, there was a continual evaluation and verification of the data.

Reliability refers to replicability of a research project. In order to enhance the reliability of the study an effort was made to define and describe the details regarding the data collection and analysis methods used and many examples of verbatim data are included in the research findings (LeCompte & Goetz, 1982). The reliability of the data was facilitated by tape recording the interviews so that the verbatim conversation was available for data analysis. All data collection, transcribing, and data analysis was carried out by the investigator. Efforts to ensure the reliability of the data analysis included using the constant comparison method of data analysis as outlined by Glaser and Strauss (1967) and clarifying and verifying the data with informants at various stages during collection and analysis.

External validity refers to the generalizability of the research findings and the extent to which the findings of the research may be applied to other situations and settings (LeCompte & Goetz, 1982). Due to the small sample size and the non-random selection of the informants, generalizability to the population at large is limited, and must be restricted to a population of women with similar characteristics to these informants. The theory developed in this study that explains the maternal processes in livebirth following stillbirth is theoretically generalizable and can be tested in other populations.

Ethical Considerations

The researcher received ethical approval for the study from the Faculty of Nursing Ethics Review Committee. When the research proposal was modified to expand the search for informants, approval for the revisions was received from the committee. In addition, ethical approval was received from both the nursing and medical hospital ethics committees in the facility first used as a site to recruit informants.

Each informant signed an informed consent form (See Appendix G) after being told of the purpose, objectives and time commitment they needed for the study. Each informant was made aware that they would not be identified by name in the study, that they had the right to decline to participate in the study, that they could withdraw from the study at any time, and that their decision not to participate or to withdraw would not influence the care that they received. Furthermore, the informants were aware that if they decided to withdraw from the study, it was their decision whether data collected up to that point would be used in the study. No informants withdrew.

In the event of a repeat perinatal loss, the investigator would have visited the primary informant, if desired, prior to terminating with the informant. This was not necessary as all primary informants delivered live healthy babies. Interviews were conducted at a time that was convenient for the informants and the investigator answered any questions the informants had regarding the study.

The identity of the informants was known only to the researcher. In the transcripts, field notes, and final report the informants were referred to by assigned fictitious names. Fictitious names were also given to people the informants talked about such as other family members and their physicians. The tapes, transcripts, and field notes will be destroyed when the final report is completed. A short summary of the study findings will be made available to the informants who participated in the study and to the physicians who referred clients to the researcher.

A counsellor had been identified who was able to counsel any informants should the study precipitate any feelings regarding the previous pregnancy which the informant would like help in resolving. None of the informants required referral to this counsellor.

Chapter IV

FINDINGS

In interviewing the women it became evident that the initial purpose of the study, to focus on attaching behaviours, was too limited to capture the process that women experienced in subsequent pregnancy following stillbirth. While behaviours relating to attaching were altered by the mother's fear of recurrence of loss they were only part of the broader process of livebirth following stillbirth.

The four principal informants and the five alternate informants contributed their individual experiences regarding livebirth following stillbirth. Although their stories were unique, it became obvious throughout the data analysis that a common experience was shared by all the participants. It is this common experience that is presented in the findings as the maternal processes that occur in post-stillbirth pregnancy and birth. The chapter concludes with a summary of the findings and a schematic model illustrating the maternal processes [illegible] livebirth following stillbirth.

For clarity of presentation, the data are presented in a linear fashion. The process of livebirth following stillbirth however, occurs as a matrix centred around the core variable of fearing recurrence. In attempting to describe each step as a separate entity there is some overlap in description of categories: for example, the consequences of one category may be described again as antecedents to another.

The number following an informant's name refers to the interview from which the quote came: number one indicates an interview in the last six weeks of pregnancy, number two indicates an interview in the first two weeks postpartum, and number three indicates an interview held between four and six weeks postpartum. No number was recorded for the alternate informants who were interviewed one time only in the antepartum period (See Appendix D for a list of informants and interview schedules).

Discussion of the meaning of these research findings and the relationship of the findings with the current literature is presented in the next chapter.

THE PROCESS OF LIVEBIRTH FOLLOWING STILLBIRTH

The study focused on the current pregnancy which followed the stillbirth and informants were aware of this. The guiding questions, however, elicited some information regarding each informant's previous pregnancy and delivery experience. Although it was not the intent in this research to investigate the experience of women immediately following a stillbirth, some description of this experience from the informant's perspective is necessary in understanding the effect of the event on the subsequent pregnancy.

In sharing their experience of stillbirth, informants made many positive and negative comments about the nursing care they had received (See Appendix H). Informants hoped that participating in the research study and sharing their experiences might improve the nursing care for other women in the future.

The Worst Has Happened

As is common with pregnant women, the informants knew that there was a possibility that something untoward could happen to their baby during pregnancy and birth. However, when the stillbirth occurred it was perceived by the informants as the worst thing that had ever happened to them.

> I know what it is like to give birth and to have a stillborn baby, and, I mean, what is worse than that? Nothing.(Gracel)

The informants indicated a variety of grief reactions that are well documented in the literature: anger, shock, disappointment, emptiness, horror, and denial (Kubler-Ross, 1969; Lindemann, 1944).

> I was so mad. Really angry. I didn't care any more. I just didn't care. ... I put myself into shock, like, both mentally and physically. (Linda)

> It was just that I felt, you know, very disappointed. You know, not disappointed, lost. (Lucy)

> The horror of it all just hit me. (Gracel)

Giving Birth to Death

Finding out that the fetus had died in utero was a major shock to the informants. Their immediate response to the diagnosis of intrauterine death was to want the baby out.

> Right away I wanted the baby out. (Grace1)
>
> And they [nurses] looked and they said "He is dead, he is dead". I don't know. I just freaked out. "Get him out of me!" (Linda)

The length of time that the informants carried the dead baby in utero varied from a few hours when the stillbirth occurred during labour, to nearly three weeks for Grace who was at 28 weeks gestation when the intrauterine fetal death occurred. Tina thought that knowing the baby was dead prior to the delivery made acceptance of the death easier. Linda wished she had prior knowledge of the death and time to adjust before delivery.

> I felt very good that I could handle the labour. ... The baby died in utero before my labour started which makes a big difference too. If I would have not known that the baby was dead before my labour started then I think I would be probably feeling differently.(Tina1).
>
> I think if it had of been just a normal stillbirth and I had known about it before ... it wouldn't have been half as bad...(Linda).

Grace came to embody the dead fetus and was reluctant when the possibility of delivery was near.

> Then I got used to the baby being inside and I really had a hard time, I didn't, like, I started being quite comfortable with being pregnant even though she was dead. (Grace1)

The initial reaction of the informants when faced with the prospect of going through labour and delivery in order to deliver a dead baby was abhorrence. They would go through this traumatic ordeal with no reward in the end.

> And, but with this, I went through all the pain and everything and there was like no reward sort of thing. Which is sort of selfish, but that is how I feel some days anyhow. (Sarah)

Despite their expectations of an abhorrent experience, when informants actually looked back on the labour and delivery experience they spoke positively about it.

> It didn't hurt as bad as I imagined. (Sarah)

> It was really the best that it could be, I think, going through that type of thing. I couldn't have expected, you know, any more. (Tina1)

Grace even found the labour with her stillborn infant a more positive experience than the labour and delivery of her live child.

> It wasn't sort of, um, as, that's kind of a funny way to put it, as pleasant as the first experience in a sense. I mean, it was nice, the outcome, but, um, I don't know, maybe there wasn't the drama or something.(Grace2)

During the labour and delivery of the stillborn child, informants expressed that there was an unreality that the child had died. The informants seemed to dissociate themselves from the reality of their loss.

> I didn't really focus on the fact, it didn't seem real to me that the baby was dead. ... I think I really protected myself that way in dealing with only as much as I could handle. (Tina1)

> I never really thought about the baby as the baby in a sense, do you know what I mean, when I was

going through labour then. (Grace1)

The interaction that informants had with their stillborn child was important to them. The informants who did have the opportunity to have interaction with their stillborn child, spoke very positively about this experience.

> We looked at them and we held them and we took pictures and everything... and it was I think the best thing. (Sally1)

> I can't over stress holding your baby when the baby is born. Cuddling him or her and counting those fingers and toes and being a mother.(Tina1)

> They showed him to me and they said "Do you want to hold him?" And it was like "Yes, give him to me", you know. (Marie)

Five of the informants did not have the opportunity to hold their stillborn child and regretted this.

> No, I didn't [hold her baby]. I wish I had. That was the one thing that I wish, even if she [nurse] had just said "You know, he looks OK". Because I was still afraid of what he looked like. (Sarah)

> After I had her they gave me a chance to hold her but because of the stuff that they had given me for my C-section I was so out of it I didn't take that opportunity. And I feel now [starts to cry] that I should have. (Rita)

Even Lucy who had not had the opportunity to spend time with her stillborn child harboured regrets 31 years later.

> I just remember looking up and I saw the nurse carrying the baby away and I could just see the backside of it. And it was a very plump little, it was a little girl, very plump. ... I don't know. I often would have liked to have had just a better look at the baby. I don't know. It is so hard to say. (Lucy)

Disillusionment

For the study informants, the experience of stillbirth shattered their whole world. The informants could not believe that such a devastating thing could have happened to them.

> We didn't realize that these things would happen to us (Helen1).

> And when it did happen, you can't believe it. Like, you know, now you are a statistic [laughs], you know, you are not just a, just one of the regular people, you are one of the people that it happened to. And that just, it's just incredible that these things happened. (Marie).

For many of the informants the loss of their child was the first time they had ever had any one close to them die. The unknown experience of grief may have compounded their feelings of sadness.

> That was the first time in my whole entire life that I had not been able to have something that I wanted to. I had not had losses either. I hadn't had significant people die. (Carla)

The informants' confidence in the process of pregnancy as being a normal event and in the health care system was shattered.

> I never assumed that anything would go wrong. So it is sort of, I didn't think anything of it. ... I never knew that babies died actually, to be honest, I just didn't. I just sort of thought that it was taken for granted. (Sarah)

The disillusionment that occurred with the stillbirth, made the women feel vulnerable regarding pregnancy.

> It will never be the same again, I know that. ... You become sort of, well it's not really, you just become sort of sceptical. ... It is like a little

> knowledge is quite dangerous really. ... if you don't know things can go wrong, then you don't think about them. But when you hear things that can go wrong then all of a sudden you start thinking "Oh God, maybe I can get that". You almost become paranoid. (Sarah)

The experience of stillbirth left the informants with a feeling of having failed. They felt that they had failed in one of the basic tasks of being a woman and that their bodies had failed them.

> And the other thing I never noticed or I never thought that women would feel that when those babies died you felt less of a woman. Why you looked at women who had babies or children that, I shouldn't say you looked at them with envy or, you felt lesser of a person. And it was just, I never thought that one could feel that, you know. (Sally1)

> When you lose a child because your body fails you, it's worse... (Marie)

The informants felt not only the failure of not producing a live child, but also the failure of not having a child to mother. There was a loss of the plans and dreams that they had of becoming a mother.

> Not being where I wanted to be a that time. And that wasn't what was planned or dreamed about or anything like that. (Grace1)

> And then I planned so much with Joseph, like I quit my job and I did this and I did that, and I had everything planned out perfectly and then it all got screwed up anyway. (Sarah)

Guilt and Blame for Stillbirth

All informants sought a cause for their loss and often ended up blaming themselves. The causes of self blame were many and varied. They included such things as marital problems, moving, sexual intercourse, and physical activity. One of the most common causes of guilt was working too hard during the pregnancy.

> I don't think I would have worked so hard, because I did. I kept working and I worked very hard. I worked day and night and Sundays. I was pretty stubborn and stupid it that way that I didn't realize that you had to slow down a lot. (Linda)

The informants often could recognize that their self blame was irrational but the guilt feelings persisted.

> I did a significant amount of blaming myself. You know. Well we shouldn't have done this and we shouldn't have had sex and we shouldn't have gone on the raft trip and `Oh my God'. And I mean people do those things when they are pregnant and they don't have miscarriages. (Carla)

It was not uncommon for the women to review their antenatal care and evaluate it to determine whether any blame could be placed with the medical staff. This evaluation had significance in the subsequent pregnancy in determining whether the informant would seek prenatal care from the same physician. Five of the informants sought antenatal care from another doctor in the subsequent pregnancy.

> This was the question that I think it always nagged me in the back of my mind that Dr. Jones sent me home on that Wednesday. ...
> And of course, you know, you are trying to decide shall you go back to the same doctor. Was there anything they could have done? (Sally1)

The guilt informants felt regarding the stillbirth tended to continue unresolved.

> It's just like it happened yesterday, that I had done that. That I had killed her. (Grace2)
> I don't know if it will ever be resolved. (Grace3)

An additional guilt was felt by informants when they perceived that they had failed others by not producing a live child.

> I woke up again and then it hit me, that, our daughter Vicki was four, so, not quite four, three and one half, and so she was really looking forward to this baby. Here I am without a baby and, I don't know. (Lucy)

> You are feeling more sorry for people around you. Like my Mom and Dad were just having a terrible time and I just sort of felt really bad for them. I felt really bad for my husband. (Sarah)

When the reason for her stillbirth was unknown Grace found this hard to accept. She tended to continue to blame herself.

> The guilt and feelings are still there. I don't know, I think with other people in the group [Perinatal loss support group], a lot of them have reasons. ... It looks like they are not bearing it on themselves as much. (Grace3)

Sarah knew the reason for her child's death. The fetus had anencephaly. Despite knowing the reason for the loss, Sarah did not perceive that this made acceptance of the loss easier.

> Well, you know,... I used to think "Well, at least I have a reason". But there is not really any reason why,... why was it anencephalic in the first place... and you go through all these genetic testing and you go through all this and all they say is "It is 50% environmental and 50% chromosomal", you know. So they don't really know

> either. Like when you blame the environment that means that you are saying that you don't really know why.... It is like there is no reason. There is a reason but they don't know why it happened. (Sarah)

However, Sarah did not blame herself for the loss as was common with other informants. Perhaps, with the diagnosis of anencephaly, it was inevitable that the child would die and Sarah knew there was nothing she could have done to prevent this.

> There was nothing you could do. There was nothing. These things happen and he [husband] said "You roll the dice and you take your chances. If it doesn't turn out well, you can decide to get back on the horse again or you just, you don't". (Sarah)

For Carla, knowing the reason for the loss made it easier for her to accept it.

> It is not as bad once I sort of had a good idea of what really did go wrong. It was the not knowing. (Carla)

Marie delivered prematurely because of severe toxaemia due to underlying renal disease. Marie's guilt related to the fact that her unborn child was normal in development and that it was the failure of her body to perform properly that led to his demise.

> There was nothing wrong, the autopsy showed there was absolutely nothing wrong with him. And that bothers me the most. If they had gotten him out. If they had, if my body hadn't of shut down the way it did he would have been fine. (Marie)

Coping After Stillbirth

For two of the informants, their religious beliefs helped them cope with their loss.

> Your faith has a lot to do with it too. We both have, my husband and I have a lot of faith and we pray and that makes a big difference to know that your baby isn't just gone into nothing. That he is in heaven or whatever. So, you, it's got to have a powerful part in you recovery. (Tina1)

Three other informants talked about the loss of their child as nearly a spiritual experience while at the same time claiming not to be religious.

> I feel my baby that died is my guardian angel. And anything that goes right in my life I always think that it is him pulling strings for me. I am not a religious person but that is my feelings.(Marie)

Writing provided a means of coping with stillbirth for three informants. It may be that writing provided a non threatening medium for expressing the informant's feelings. Perhaps writing was a way of making the abstract feelings of loss and grief concrete, a process easier than verbalizing feelings.

> I do a lot of writing still. Poetry about him and stuff. ... And so I keep things that I felt at that time or am going through.. I don't really have any friends that I can talk too about this kind of thing. (Linda)

> I keep a diary. I kept a diary for all my pregnancies. ... It's very painful, like the first diary, that's painful to read, it's incredible. (Marie)

There was a certain feeling of personal growth from having coped with the experience of perinatal loss.

> Gee's, I've got, like that's happened in my life, and God forbid, like I'd hate it to happen again but there is a certain knowledge that's been gained too after it has happened. (Grace1)

Eight of the informants felt a lack of support following the stillbirth and would have liked more help at that time. They would have liked to have known that they were not alone.

> I would have liked someone to call and talk to me so that, they didn't tell me that, statistics right, that there was, you know, you're not alone, it's one of the very big things, you're not alone because I mean, it does happen because you feel like a bit of a freak, you know. (Grace1)

Attempting to Replace

Following the occurrence of the stillbirth, the reaction of the informants was to get pregnant as soon as possible to replace what they had lost.

> I just had to do, that was, I just had to [get pregnant], I could not wait. I don't know, for some reason it was really important for me to get into that. It was just because I felt ripped off of everything, and my arms, you know, everything was just so empty that I just couldn't take it. (Grace3)

> That was to replace [wanting to get pregnant right away]. I tell you, I wanted to get pregnant immediately because you, like you're just, you just die inside. (Sarah)

Informants who did wait longer than three months spoke of wanting to get pregnant earlier.

> But I waited long enough, I wanted to get pregnant right away as soon as it happened, but the old body just said no, it just wouldn't.[pregnant within 4 months](Sarah)

> And probably I should have waited longer but I, if it was up to me I would have gotten pregnant right away. And I just wanted to have a baby so badly. So six months was about as long as I could wait. [pregnant within 6 months](Marie)

While informants willingly became pregnant again in order to replace the child that was lost, they resented when this was suggested by others.

> I remember one of the nurses coming in also and sat with me for a while. Her advice was "Try to have another child as soon as possible to fill that void". At the time, I don't know, you are not thinking that clearly. You are just thinking of your loss and I guess trying to adjust to it. (Lucy)

Although the informants desperately wanted to be pregnant again they felt ambivalence once the pregnancy was confirmed.

> When I first found out that I was pregnant there was a lot of ambivalent feelings because you kind of have to accept, for the first couple of months, accept the fact that you could have to go through this again. (Tinal)

> I feel really mixed up about this pregnancy. ... I thought for sure I was pregnant. So I was hysterical. Like all of a sudden I was just hysterical thinking "Oh God, I am pregnant again". So then I go to the doctor and have the test and he said "No, you are not pregnant". Then I am devastated because I'm not pregnant [laughs]. (Sarah)

Even Marie who had successfully delivered a live child felt ambivalence at becoming pregnant again.

> This is my third pregnancy so I have, already had a live child. But even so I was still quite leery about getting pregnant. (Marie)

Fusion of the Pregnancies

Informants had a need to replace the child that was lost, but with the confirmation of the pregnancy, they were faced with the reality of this child replacing the stillborn child. This led to confusion over wanting to replace what was lost, while at the same time not wanting to negate the child that was lost.

> Yes, no, but then, on the other hand you sort of do, [want this baby to replace the stillborn child] that's why you, but you know that it can't. They are two distinct people. And it is just, it is just that it gets a little blurred sometimes. ... I just thought, I just wanted another one. I wanted to hear crying and I wanted to hear all that kind of stuff. So it was like replacing something that you had lost. (Sarah)

The short pregnancy spacing may have contributed to the informants fusing the two pregnancies in their minds.

> But I am glad, [I didn't get pregnant immediately] because otherwise I would have confused the two pregnancies because even waiting the length of time that I did [four months] I still sometimes it seems like a blur. I have just been pregnant for almost two years now. ... it feels like I have been pregnant all along now. Just continuing on. (Sarah)

> I almost started feeling that it was the same baby once I started getting close to that time, about 28 weeks. (Gracel)

All informants verbalized concern over wanting a healthy child, regardless of the sex of the child.

> Because we don't mind if it is a girl or a boy as long as it is healthy. We will love a healthy baby. (Helen1)

At the same time, informants thought that if this child was the same sex as the child that was lost, they would be more likely to fuse the two children. It would also be a reminder of their grief.

> Maybe it would be even better for me, which is crazy, but just to have a boy because I am so conscious of, initially that I'd put anything on, like, I don't want to do all that replacing bit. (Grace1)
> What if it was a little girl? How would I be looking at her? Would I be looking at her as, could this almost be like Jane? Like her? (Grace2)

> I wanted David to be a girl. I thought, in the beginning of that pregnancy I really thought he was a girl. And I guess I wanted him to be a girl so badly because I didn't want, [pause] I didn't want to be reminded, or I didn't want him to look like our first child or have any resemblance or anything. (Marie)

Four of the informants expressed wanting to be the mother of a girl infant, while at the same time saying that they wanted to provide their husbands with a boy.

> So I think in a sense this has made it easier, in a sense that Bill's really really happy and I think this is what he wanted. He is so proud he has a son now. (Grace2)

Carla used the name for the stillborn child in the name for the next child and this created fusion of the two children for her.

> And then there is another Samuel Brian really but it is two babies. Sounds kind of strange. ... So he carried a piece of that baby. (Carla)

Differentiation of the Pregnancies

As well as informants experiencing the fusion of the two pregnancies, ten of the informants referred to attempting to differentiate between the unborn children.

While fusion appeared to be an unconscious act, differentiation appeared to be a woman's conscious attempt to distinguish between the two pregnancies and the two unborn children.

It appeared that coming to know the lost child and mothering the lost child made differentiation easier in the next pregnancy as the lost child was more likely to be perceived as a distinct individual by the mother. The mother's experience of her lost child was gained through fetal movement, fantasizing, viewing the lost child on ultrasound and holding the lost child.

> I have sort of fantasized about their personalities so it has really made them individuals. (Marie)
>
> I think it does [have its' own personality], I think they are all different because, Joseph, he never kicked like that at all. (Sarah)
>
> So I haven't denied it at all and that's really helped me to work through and to accept this next pregnancy because it isn't the same as the other one. You know, there is a different baby inside. And I know that because I have held that other one. They didn't sweep it away from me and put it away in the morgue or whatever. This baby is going to look different and is going to be different. (Tinal)

Sarah acknowledged that coming to know the stillborn child was difficult.

> It is just that you don't really have anything to compare it to. Like if, if, if he had lived, even for a couple of days. (Sarah)

For Sarah it was important for her to acknowledge the lost child during this pregnancy. Perhaps this was to help her differentiate the lost child from the live fetus.

> Yes, Yes, I am really glad I have them [pictures of Joseph]. Just lately though, you know. It's really, it must be the maternal instinct or something that you get, because, before, I never looked at the pictures for like, three months after it happened. I never, I wouldn't even look. I wouldn't do anything and then when I was pregnant, all of a sudden it seemed very important that he couldn't lose his place in the family. (Sarah)

Except for Carla, informants did not wish to use the name of the stillborn child for the next child.

> We had a name picked out. ... No, no, no, as much as we like the name we didn't [use this name for children born later]. That name was meant for someone else. (Lucy)

Grace was bothered that the experience of the stillbirth affected what was happening to this next child.

> Everyone keeps saying that this is a different baby, so then, let's go with that and say, well, if this is a different baby let's let it go to term or let's not put it through all these tests. You know, why does it have to because its' sister died. (Gracel)

Residual Grief

The pregnancy caused fulmination of the informants' grief.

> When I did get pregnant I was still grieving and am still upset about my first one. It's still too sad. I mean I can talk about certain elements but it's still very hard to talk about her and how she looked and everything yet I did it when it first happened but it's awfully hard and always will be. ... I just, I would rather, I wanted to talk about that [stillbirth] rather than talk about me being pregnant again. (Gracel).

> And every once in a while I will have a relapse and think back about the first baby [cries]. (Rita)

Marie acknowledged that although the grief never completely goes away, it is lessened with time.

> You know, I don't think there is enough time in the world to get over grieving. I don't think you ever really get over it. I just think you learn to live with it. (Marie)

By just going through the experience of pregnancy again informants were forced to relive the loss. Things such as going back to the hospital for non-stress testing or for delivery rekindled the memories and fostered fearing recurrence.

> I was right next door to the room that I had been in when my first baby died. ... And when they started [induction] I asked them to turn the monitor away from me so that I couldn't see the heartbeat because I had watched my first baby die. I had seen his heartbeat go. And I didn't want to see that again. (Marie)

The experience of having lost a child made the informants very aware of the value of having a live child.

> I feel so bad for him. That is how I feel the most. I feel that he has been cheated out of life. He never got a chance. Sometimes with David I think, "Oh you are so lucky to be here David. You just don't know how lucky you are". ... Oh God, for sure, I appreciate him so much more. (Marie)

> You certainly realize when you lose a baby that you have lost a very precious thing, you know. (Tina2)

Fearing Recurrence

With the occurrence of stillbirth, the informants became disillusioned and perceived that perinatal loss could conceivably happen to them again. While fearing recurrence was triggered at the time of the stillbirth, confirmation of the next pregnancy provided a tangible thing to be lost.

Going through the process of pregnancy provided the scenario for reliving the previous loss and fearing that the outcome would be the same.

> Oh my God, is something happening to this one too. (Grace2)

The vast majority of pregnant women fear the possibility of something untoward happening to their child, but for the informants who experienced a stillbirth, their fear was of recurrence rather than occurrence, and was based on their own personal experience.

> The first pregnancy too I remember having concerns but they weren't as real as this time. This time it is more real for me to think that I am not going to have a baby to hold. You know, it's more, it's more of a reality for me. ... Those fears that every first time Mom has before she has even given birth or had a stillbirth, those are present but they are not as real as they are to me. Like I, these things can happen to me.(Tina)

> Like you still are always thinking "Well, God, I just can't believe this is actually going to live". (Sarah)

Fearing recurrence caused a decrease in confidence about the pregnancy outcome being a positive one. The informants remained unconvinced that they would deliver a live baby.

> I will believe it when I see it or hold it. (Grace1)

> I was, according to my record [Blood sugars], I controlled it very nicely too [diabetes], but

> still, until the baby was born I wasn't sure. (Helen2)

Informants also feared that should the child be born alive, then it would not be a healthy infant.

> You might not get toxaemia but there is so many other things out there that could happen. (Marie)

> I believe that the baby's going to be alive but is it going to be brain damaged now because of all the stress I've had or is it going to be this or this, like, you know. (Grace1)

Fearing recurrence of loss was not resolved with the birth of a live child, but continued in the postpartum period.

> I was still picking out all these negative things that were coming at me. I couldn't understand why they would say he is a healthy, he's a healthy boy, yet he has jaundice. And it's the same when she was born. Jane. You had a healthy baby girl. Well, I mean, like nothing was wrong with her [she was healthy but dead]. Well, you guys are giving me mixed messages here. (Grace2)

> After the baby is born they have some monitors to monitor the baby's heartbeat and everything? Because we heard they have some, like sudden infant death babies. (Helen1)

Not only did fearing recurrence continue in the postpartum period, but three of the alternate informants also experienced fearing recurrence in additional pregnancies despite the birth of live children following the stillbirth.

Anxiety

Fearing recurrence manifested itself as anxiety. Informants perceived that the uncertainty associated with fearing recurrence was even worse than knowing a bad outcome.

> We can just get it over with no matter what we are faced with but get this pregnancy through. (Grace1)

Anxiety was evident early in pregnancy and represented a long waiting period to the informants, before the anxiety would be resolved.

> So like it is going to be an awful long pregnancy. ... It is just getting by day to day. That's all really. You, actually, you wish it were over. ... I just hope it is all over soon.[said at 23 weeks gestation](Sarah).

> There is a lot of anxiety and bad dreams. ... I have to sit and wait until at least May. (Linda)

It was apparent that anxiety increased as the informants approached term. Informants who had previously delivered a live child following the stillbirth still remained anxious during pregnancy.

> It makes for a, for a pretty trying time really. (Carla)

> I think that you could have twenty babies and you would still be nervous. (Marie)

Even 31 years after the stillbirth Lucy remembered the anxiety she had felt during her subsequent pregnancies.

> Um, I was sort of worried, always about, will this one be OK. (Lucy)

Anxiety related to labour and delivery was both related to concern for the baby's wellbeing and concern over being able to cope with the labour. The informants could not picture themselves delivering successfully.

> But this time I don't associate labour with giving life. Like, it's like it's associated with death. Like it's just, that's how it ends sort of thing. ... Like you still are always thinking "Well, God, I just can't believe this is actually going to live". And you can't believe the labour part where they actually cry or whatever. I think that is probably the biggest, like I think about that a lot, like if it's going to cry. I hope it screams. (Sarah)

Fear of the outcome of the labour made three of the informants fear the prospect of actually having to push the baby out. This fear resulted in these informants wishing to avoid labour and delivery altogether by having a cesarean section.

> Oh yes, you had a baby. You had a stillborn, but I almost feel like I would probably be more retaining this time. Harder to let go, where as before I didn't have a major problem at delivery letting go and having the baby come out or anything like that.(Grace1)
> I was really hesitant and really lots of times wouldn't push as hard as they wanted. I don't know if that happens anyway but I was just laying there and gave these little whimpy pushes too you know. Part of that is tiredness and part of that is, you know, I don't know if it was just me holding back or not. (Grace2)

> I was thinking that I would go for the cesarean and ask the doctor and tell him for emotional reasons I can't go through... (Sarah)

For four other informants the labour and delivery proved to be a more positive experience, especially compared to the anxiety associated with waiting for delivery.

> The labour I can honestly say, the labour was the easiest part of it all. I kind of thought of that before even, "I have a feeling that when the labour starts it will be all down hill" because the worry and the emotional stress that a person

> goes through just before is far greater than any amount of physical pain. (Tina1)

> And I completely forgot. I didn't even think about the first baby. All I could think about was getting the baby out of me alive. ... And I also thought that I am going to get to see this baby and he is going to be alive and it is going to be wonderful. (Marie)

Guilt in Subsequent Pregnancy

Informants carried the guilt they had experienced for the stillbirth into the next pregnancy. They feared that if they repeated whatever they felt guilty about in the last pregnancy, that they would jeopardize the current pregnancy. Feelings of guilt influenced the behaviour of the informants. Most of the women attempted in this pregnancy to remedy, by their actions, the things which they thought had caused the stillbirth previously.

> I try to do anything which I thought last time was not enough. I try to make it up this time. (Helen1)

In order to prove to herself that she had not been responsible for the stillbirth of her first child, in her second pregnancy Grace wanted to indulge in doing the things that she had felt guilty about.

> So I think when I got pregnant again, rather than avoiding doing those things that I had done before which a lot of people say, you know, they are so cautious and they are not going to, everything is going to be different this time, I think I indulged more in doing the same things because I wanted to, still had to prove in a sense to myself, that's really screwy, but was it that thing in fact. (Grace1)
> I was almost wishing things would happen just so

> we could make sure that isn't why. (Grace3)

Anniversary Dates

Two anniversary dates were significant to the informants. The first was the anniversary calendar date on which the stillbirth occurred. Three of the informants became pregnant again within three months of their loss. The anniversary date coincided with the expected date of confinement in the next pregnancy and precipitated residual grief.

> I just got sad about her, that she died at that time and was just sort of reliving how I was feeling, you know. Just, I think it was really just I was more emotional about her. (Grace1)

The second anniversary that was significant to informants was the gestational age at which the stillbirth occurred. Although their confidence increased somewhat once this anniversary date was passed, fearing recurrence continued throughout the pregnancy.

> One of the things that happened in the pregnancy with David that was really good for me was I guess, like I said June 19 was the day that our baby died, so on the anniversary of his death was the day that I turned 28 weeks with David. It was just the way it worked out. So it was a really really sad day for us because of the grieving, or the anniversary, but it was also a very happy day because we knew we had made it to 28 weeks. (Marie)

For Marie, it was important not just to get past the gestational age where the stillbirth occurred but to get to the point where the infant would be viable if it was delivered.

> It's really, it's really hard right now. This past couple of weeks. ... When I am past 28 weeks I will feel a lot better.(Marie)

For those women who had a stillbirth some years previously the anniversary remained as a time to remember the child that was lost.

> I mean I know every year on September 15th I always think, and it was in 1980 when I lost the baby so it is like it is very easy to keep track of how old it would have been, like nine years old and stuff. I think of what it would be like to have a nine year old son. ... I mean the last time I cried about that baby was last September 15th. And maybe the next time I cry about that baby will be September 15th coming up. (Carla)

Enduring Fear of Recurrence

Throughout their pregnancies informants were faced with conflicting feelings of fearing recurrence, while at the same time feeling confident that things would go well. It was as if fearing recurrence and feeling confident were on a balance scale. Fearing recurrence was always present but it was less pronounced at times when the informants felt confident. Linda, who was carrying twins, had a dream which demonstrates this dichotomy of feelings.

> About three nights ago I had a dream that I couldn't make it to the hospital and that I had to have an emergency C-section... And so they cut me open and they pulled out the first baby and he was a boy and he weighed about ten pounds and he was really healthy and good but the other one was really deformed and dead. (Linda)

A number of things appeared to foster confidence in the informants. Quickening and the presence of fetal movement reassured informants of fetal wellbeing.

> I think my baby moved at 19 weeks. Then we felt safer. (Helen1)

> I am feeling really quite good about it and confident, the baby's moving a lot. (Tina1)

> I know it feels good because the baby is kicking me and stuff. That is the one thing that I find, if the baby doesn't kick me I really start to have a fit. (Rita)

Normal results of antenatal screening tests increased informant's confidence.

> Actually yesterday was the first time I heard the baby's heartbeat and that, that made me feel better. (Carla)

For the three informants who had successfully delivered live children following the stillbirth, two felt their previous success increased their confidence in this pregnancy and one did not.

> With this one I was more confident than with David. (Marie)

> Yes it does [increases confidence to have a live child]. Because it helps you to think more positively because after having lost Melissa, that's why when I miscarried I didn't think anything was possible any more. It was so negative and stuff. But now I feel a lot more positive. (Rita)

> Not really, no. [having two children that survived does not increase confidence]. Um, not really, no it doesn't. I suppose that it should. (Carla)

The gestational age also seemed to play a role in whether or not the informants were confident. Confidence appeared to be low early in the pregnancy and when approaching labour and delivery.

> Well, I found that the first three months was quite hard and I am finding right now is quite hard. Somewhere in the middle, between, you're starting to cope again. (Sally1)

While fearing that perinatal loss could conceivably occur again, two informants also expressed a joy regarding fetal wellbeing. This joy was for the fetal wellbeing of the present regardless of what the outcome might be.

> I feel very positive because the baby is alive inside and well inside of me now. To me, that is something very special. It's something that I don't take for granted or think that the only thing that matters is that this baby is born alive, for the baby is alive inside me now. (Tina1)

One of the parameters of fearing recurrence was that whether or not perinatal loss happened again was not under the informants control. Informants sought to maintain control over other aspects of their pregnancies as much as possible, perhaps to compensate. For Tina, maintaining control over her emotions was very important.

> A person just has to take every day and prepare yourself and remember that you are going to have to go through this. It doesn't matter what you do, you have to give birth to this baby. [Laughs]. And you don't really have much control you know. You can choose to have control over how you respond but, it, you are not really going to make much difference. You can fight it or you can go with it. (Tina1)

Tina felt satisfaction that she had maintained control during labour, while Grace, who had labour induced, felt labour was not in her control and this caused her some distress. She regretted losing control over her own body.

> And really my pain tolerance was pretty high because I had really powerful contractions according to that little monitor there and I dealt with them just fine. And that made me feel good too. I was successful doing that, maintaining your control. (Tina2)

> No one was really saying, except Bill [husband] finally, it is your body and you can decide what you want to do with it. ... Like even if I'd had the choice, who knows how that delivery would have gone or that labour. I tend to think I would have been more positive about it. I don't know. (Grace2)

Marie felt very positive that she had accepted the responsibility involved in embarking on a high risk pregnancy and had control over this decision.

> I knew what could go wrong but I did it anyway because I wanted him that badly, and it makes me feel good that I took control and gave life to this person that I wanted so badly. (Marie)

Resisting Attachment

One result of fearing recurrence was a resistance to attaching to the unborn child.

Resistance

All informants were hesitant to attach to their unborn child antenatally for fear that the fetus would die and they would once more be hurt.

> Don't do it. You're just getting in worse, you know what can happen. ... Not getting that huge closeness or really emotional about it like you did with your first one at the beginning. (Grace1)

When informants found out that they were pregnant again following the stillbirth, they wanted to maintain a low profile and conceal the pregnancy from others for fear that the loss would recur.

> And then I was scared to death and I didn't tell anybody, well, I told my husband but that was it. But I didn't tell a soul. Not anybody. It was easier that way for me because I really didn't have to talk about it because I just wasn't ready to talk about it at that particular point. (Sarah).

> I didn't tell, Oh I think probably I was passed my three months when I told them ... the first time you were just all over. You were just bubbly. You were just totally excited. ... You want to hide it. I think if anything, [laughs] what we were thinking is "Let's go over to Europe and have this baby". And I just don't want anyone around. (Sally1)

For Carla, concealing the pregnancy also meant not informing her two children that she was pregnant in order to protect them from the hurt if the loss should recur.

> Um, the things that are different about, that I think must be different about, that I think must be different when you have two children and you lost the first one um, is that I didn't tell my children for a long time that I was pregnant in case, because I did not want to deal with telling them that I had lost the baby. (Carla)

Concealing the pregnancy permitted the informants to resist attaching to the fetus. Informants were ambivalent about being pregnant again and did not want to acknowledge the presence of the unborn child.

> But I think for the longest time, the best way to describe it is, I didn't acknowledge this pregnancy, ... This is just something which you would like to hide. (Sally1))

> When we first got pregnant you were just sort of

> ignoring it in a way, part of you was "Oh yeah, you're here, yeah". Not getting that huge closeness or really emotional about it like you did with your first one at the beginning. ... I didn't tell anybody. Like, I felt OK about it but... I didn't want that attention on me again... People are always talking about the baby and ... you're not really there at that time.(Grace1)

For Sally, the combination of the unreality of being pregnant again, the desire to conceal the pregnancy, resisting attachment, and deciding whether to return to the same obstetrician for antenatal care, meant that she was late seeking prenatal care.

> I don't even think, I don't even think I went to see Dr. X. until three months I was pregnant. I think he was a bit shocked. He, you know, he asked for the reason and I just said, it probably was you detach yourself or you are very, very careful with your emotions. (Sally1)

Informants regretted having to reveal the existence of the pregnancy to others without reassurance that the loss would not recur.

> I guess I told them, I had to tell everybody before the ultrasound because they only do it at four months but by then I was, like, huge. ... And this time when I told them I wasn't excited when I told them. It was like "Oh my God, I have to tell them". I didn't want to tell them but like, I had to tell them because you would soon be able to tell. (Sarah)

Fearing recurrence not only led to fear that the informants would not deliver a live healthy child, but they were delayed in acknowledging the reality of the pregnancy itself. Perhaps since the previous pregnancy did not produce a viable child, this increased the "unreal" feeling in the next pregnancy.

> It's hard for me to relate that there's somebody inside there at times too, and I'll believe it when I see it or hold it. (Grace1)

> Like I couldn't believe that in two weeks I would go into labour. ... It seems very far. Very unreal. (Sally1)

> With this baby I don't know what it is. ... It is almost like I am still getting used to the idea of being pregnant I guess. I mean if, [sigh], I mean, I don't totally block it out of my mind but it would be almost as if you were talking to someone who a month ago went to the doctor and found out they were pregnant. But it isn't. I found out in November. [said at 28 weeks gestation]. (Carla)

For the principal informants, the unreality of the pregnancy and of delivering a live child, a consequence of fearing recurrence, interfered with their ability to picture themselves in the mothering role. These informants had no experience in mothering a live child.

> It is hard for me yet to picture myself giving birth to a live crying baby. It's hard for me to, um, to even look forward to, to picture myself as that. ... Just the reality I guess of raising a child and being a mother to that child. It has never happened to me before. I am a mother but I haven't experienced what most normal women experience. ... Because I have never experienced a normal delivery, a normal child, a normal baby, I've never had that, you always, I don't know [pause]. There's that hope I guess. I'm not being negative about this delivery, I am just saying that I have a hard time visualizing myself in that role. (Tina1)

The informants who had experienced mothering a live child were better able to fantasize about mothering the child from the current pregnancy. Marie fantasized about repeating the positive aspects of her previous mothering experience.

> Yes, yeah, now that I have a live baby and I know what it's like. I know what it's like to get up in the middle of the night and feed them. I know how wonderful it was with David to get up and nurse him. It was so comfortable and relaxing and loving just to lie in the middle of the night in the quiet nursing your baby and getting them back to sleep. Holding them all the time. I just love to hold them and rock them and read them stories and sing to them. ... I guess because I know how wonderful it is to have a baby. It's not that I'm not enjoying the pregnancy or that there is any problems or anything like that. It's just, I look back on when David was born and when I was in the hospital with him and I remember lying in bed and having him lying next to me and just looking at him and thinking "Oh God, he's so fantastic. He is so beautiful". And it is such an incredible feeling having this child. That is yours. That you produced. This is healthy and alive. And it is so nice to take care of them and to nurse them. To hold them, you know. It is just, for me it is like what I was born to do. Yeah, I don't know. I don't know why. I just, I really want to have this baby now. (Marie)

Both Rita and Carla fantasized about the reaction of their older children toward the new baby.

> I keep thinking what the kid's reaction is going to be. (Carla)

Following the stillbirth, the nursery was a concrete reminder of the failure to have a live child to mother. The informants remembered how painful this experience was.

> If I could go to first time mothers I would tell them don't do anything until your baby is born, you know. Because there are just too many memories, you know. (Marie)

> When I found out I was pregnant that is what we did. We went out and bought everything. Moved. And

> there was the baby's bedroom which when the baby was dead and I came home, it was still the baby's bedroom. We ended up having to leave and move to another place because it was like, which bookshelf should I put the books on? Well the one in the baby's bedroom. Well, it wasn't the baby's bedroom. There was no baby to go in that bedroom. But it was still referred to as the baby's bedroom. (Carla)

As a result of this previous pain and connected with their hesitancy to fantasize about the future mothering role, all the informants hesitated to prepare a nursery in anticipation of the coming child and to make other concrete plans for the future.

> I haven't planned anything for it. I haven't done anything. ... But you don't really. I don't anyway really think about the future. I just try and get through. And usually I always plan, I am the type of person, I like to know what is going to happen...And then I planned so much with Joseph, I quit my job ... I had everything planned out perfectly and it all got screwed up anyway. So I think, well, you know, this is obviously something you can't plan (Sarah)

> Like I haven't really prepared much. ... This time, no. And yeah, I've changed the room too. I didn't...all I was doing was bringing some of the baby things over to the other room but I didn't set it up or anything. (Sally1)

Preparing the nursery was also tied in with the residual grief that informants felt over the loss of their first child. Hesitancy over preparing the nursery was not just because of fearing recurrence of the loss in this pregnancy, but also informants wanted to avoid reliving the pain of the loss.

> Well, the nursery was done for my son, Joseph, and I still haven't gone in there. Like, I just, I

> don't know. I have dealt with a lot of it but that is one thing that, I just closed the door and the room is just sort of there. I figure I will have to go in there pretty soon. Going out and buying new stuff for this one, no, I don't want to do anything and I don't want any showers or anything. (Sarah)

> I still have diapers and things like that from the first time. That's hard. (Linda)

In resisting attaching to the fetus, informants were reluctant to personalize the unborn child in any way. Personalizing the child made it harder to resist attaching. Helen did not want antenatal knowledge of the gender of her unborn child she did not want to get to know the child.

> My husband says it is good not to know it [the gender of the baby]. If you know it, it is going to be too close. And then it is still, too, we have more confidence right now, but he is still thinking the baby is not ready to be born yet and he doesn't want to be like, the relationship to be too close and later on he will be more upset, if something, in case something happened. (Helen1)

Carla felt badly that she was resisting attaching to her child and thought that antenatal knowledge of the gender might help her to attach.

> And with this baby I want to know whether it is a boy or a girl or not. ... But I found that helped with Andrea knowing that it was a girl. And I had a relationship with her a long time before she was born. (Carla)

All of the informants were reluctant to think about the antenatal development of the unborn child. While they sought reassurance from health professionals in the form of information about fetal wellbeing, they did not seek information about fetal development or prepare for labour and delivery.

> I was really into it the last time [Prenatal education]. Every week I knew what was growing and what was happening but I don't this time. ... But as far as the stages, I wasn't really as interested in saying "Now the hands are this far now" where as before I would give Bill a blow by blow about where the baby was at. So yeah, that was kind of it. And I think that's part of it again, not wanting to get that close or being that total part of it too.(Grace1)

Two of the informants verbalized that they recognized a hesitancy to attach to their fetus and felt guilty about this.

> You also have the guilt feeling that maybe you are not expecting this baby enough. (Sally1)

Interaction with the Fetus

Despite resisting attaching behaviours, most informants did interact with their unborn child in some way. Some informants interacted with their unborn child by touching their own abdomens.

> Yes, I stroke him or her. (Sally1)

> I do a lot of touching. A lot of effleurage. (Tina1).

Grace noticed a decrease in her desire to touch her unborn child when she was anxious.

> So I started getting really anxious and all of a sudden I noticed I wasn't rubbing my belly as much. (Grace1)

Informants also spoke of their husbands touching the fetus.

> I mean there are just times that I mean he's got this touch. That when the baby is really active or whatever then he [husband] comes over and he'll sometimes put his hand on, and automatically the baby just stops. (Grace1)

> Every time he does [touch her abdomen] and he puts his hand there the kid will not move. [Laughs]. (Sarah)

Tina's husband did not want to interact with the baby through touch and Tina was surprised at his reaction.

> He doesn't really get off on putting his hand on my tummy and feeling the baby move like I would think somebody would get right off on that, you know.(Tina1)

Nine of the informants talked to their unborn child while two of the informants did not. The talk often centred around telling the baby to survive.

> I talk to the baby all the time telling her, I think it's a she, what's going on, how I'm feeling, what David's doing. What's going on in our lives. Stuff like that. (Marie)

> Yeah, I do talk to him and I say "You make sure you come out" [Laughs]. (Sally1)

> I try to say to the baby just to calm down. I also tell the baby just to stay in there. It may not be a lot of room for you right now but it has got to be a lot easier staying inside than coming out now. (Carla)

In addition to talking and singing to her unborn child Helen played classical music to her child in hopes it would be good for the baby.

> That's why we have borrowed quite a few classical piano music from the library. Just to listen to it and try to, maybe it is good for the baby. (Helen1)

Six of the informants wondered about their child's ability to perceive what was happening in their lives and their moods and thoughts. They did not want to inadvertently adversely affect the fetus.

> I always try and make sure that I am happy, because I really feel that the baby can sense if you are happy or not and then the baby will be sort of happy or not. So I always try and be happy for the baby's sake more than, which is really stupid, I don't know why I, and yet I don't believe in talking to it [laughs]. But I think if I'm happy then it might be happy. I don't know. (Sarah)

> I wonder if it is really tuned in to me. (Marie)

Four of the informants interpreted the fetal movement they felt as indicating what type of personality the unborn child had.

> I wonder what kind of personality it will have? If the way they are in utero is any suggestion to the way they will be when they are outside of you. ... This one is a lot quieter and I wonder if I am going to have a real nice quiet gentle baby, you know. (Marie)

Time seemed to decrease the resistance to attaching. This was not necessarily due to the fact that the gestational age at which the loss occurred in the previous pregnancy was past. Women whose loss occurred at term delivery began to attach antenatally despite their fearing recurrence.

> Now I love the baby. Like before you are going, you are not going to love it until it is out. Until you see it but, you are not going to get attached but you try to do all the things but you do, you know, you end up getting attached. (Grace1)

> It's like, you know, sometimes you are even afraid to get involved in a relationship because you are afraid that you are going to get hurt. So this is sort of, you know, similar I guess, a little worse actually. But yeah, I say you do. Naturally you have to. ... Because, I don't have to, you don't have to see it to love it. Like even when you are trying to stop all these emotions and everything they are still, like, they are still there. (Sarah)

Protecting

Fearing recurrence fostered the informants' behaviour in protecting the unborn child.

Protection

All informants made a concerted effort to protect the unborn child within them. They attempted to do what they could in order to prevent recurrence of the loss.

> That was the only thing I was concerned about. I only thought about the baby. I tried to do anything not to hurt the baby. That was the only thing I was concerned about. (Helen2)

The informants gave of themselves to ensure that their child would be healthy. Often their behaviour was to amend in this pregnancy what they thought may have caused the stillbirth in the previous pregnancy.

> My main project every day, my main work was watching my diet and nutrition and blood sugar. ... You know, it is worth it not to do, it is worth it to quit your job and it is worth it to eat well and control your diet well. (Helen2)

> I think I took extra precautions to make sure I wouldn't miscarry or anything like that. I made sure I rested and so on. (Lucy)

Three of the informants expressed concern that the stress they were experiencing in the pregnancy due to fearing recurrence would adversely affect the fetus.

> I probably put this child through just as much stress if not more than I did the other one. ... I believe that the baby's going to be alive but is it going to be brain damaged now because of all the stress I've had or is it going to be this or this, you know. (Grace1)

> And I think about what this baby knows is going on. If this baby can hear a lot or if it can, know what Mommy's feeling or knows if Mommy's upset or having a bad day. (Marie)

Seeking Reassurance

Informants were anxious to have reassurance regarding fetal wellbeing. Helen blamed her lack of information about pregnancy and toxaemia as contributing to the stillbirth and therefore, being informed in the next pregnancy became extremely important for her.

> Last time, like, my husband was thinking that we didn't have enough information maybe. ... This time he's more careful than before. He borrowed all the books from the library and even purchased some books from the bookstore. (Helen1)

Monitoring fetal wellbeing was important to all the informants.

> You know, I would check and see if there was any spotting. (Grace1)

> I bought a blood pressure measurement thing, myself and I test my blood pressure myself, everyday, twice a day. ... And I even bought some, those tests to test the protein in the urine myself. (Helen1)

> I wish I could wear a monitor around, you know, 24 hours a day to make sure. (Marie)

While informants were happy to have non-stress testing and ultrasound performed to monitor fetal wellbeing, they perceived other more invasive antenatal screening such as amniocentesis and oxytocin challenge testing as a threat to fetal wellbeing.

> I think that is where some of my apprehension came from last week. Why do you [obstetrician] want to do the test? These two tests? This OCT test twice? (Grace1)

> But I talked to my husband and my husband doesn't want to do it [amniocentesis] again if the baby is normal unless we must do it, otherwise we don't want to do it because there is another risk there. (Helen1)

Despite the reassurance provided by the antenatal screening tests, informants were not totally relieved of their fearing recurrence.

> I thought, well, now they have done all these ultrasound they've measured, it's growing well, they've seen it's a big, a fairly big baby and I, every time I go for my non-stress tests and they make all these comments about the baby and they feel and stuff and I went through the thing about, ... that's Ok, Yeah, I believe the baby's going to be alive but is it going to be brain damaged now. ... It's reassuring to go to the doctor and hear her put the stethoscope on in terms of that I can hear it, that's reassuring. But these other test things are just sort of getting to me. (Grace1)

Informants felt that if the tests were for the wellbeing of the fetus than maybe they were warranted but they wanted to be sure the tests were not being done for their own wellbeing. They would not want to jeopardize the fetus in any way for their own welfare.

> And if it is for me, look, I'll be OK. I can handle stuff but if it's for the baby's betterment, then, yeah, I'll go for it. But if it's just [for me], I'd rather just leave it be and not interfere too much. (Grace1)

Fetal movement was significant to informants in signifying fetal wellbeing, particularly for the informants whose first indication of the stillbirth was loss of fetal movement.

> If I don't feel the baby move I will call my husband and he will be concerned about it. (Helen1)

> I love it when they move. I think it is the most incredible experience in the world when the baby starts moving. When they don't move you are terrified. (Marie)

The presence of fetal movement reassured the informants that the child might survive.

> But every time it kicks I think, I think "Oh my God, my God, it's still alive". Every day I will be waiting for that little kick. (Sarah)

For Carla fetal movement created a dilemma. Although she wanted the baby to move as this indicated fetal wellbeing, at the same time she was afraid fetal movement might precipitate premature labour and result in fetal demise.

> Once this baby started moving around a lot and it does move around a lot, then there seems to be places where it kicks or bumps against that causes tightenings. So I am almost, I am happy when the baby is moving around because that means it's ok, I mean if it stopped moving I would be upset. But it is almost like I try to calm it down so it is not kicking quite so hard. Because I think if these tightenings keep happening you know, my cervix will open because it will think that it is

time to be born [laughs] or something. (Carla)

Seeking Safe Passage

Preparing to give up the fetus proved to be an anxious time for the informants. The informants had dichotomous thoughts regarding delivery; informants wanted to keep the baby inside them to protect it and at the same time, they were anxious to have the baby delivered, particularly if they perceived that the child was unsafe in being inside them.

> Sometimes I really just want it all to be over with and just hold this baby and other parts of me, just, maybe this is too quick. (Grace1)
> Part of me just didn't want to give the baby up in the state it was in because I knew it was safe and secure in there already. (Grace2)

Due to the anxiety of the pregnancy and the fear of recurrence informants were anxious to have the fetus delivered.

> I thought, God, I would just, if the baby could survive right now [23 weeks] I would just say "Let's do something" because I am afraid that I might, like it just, it might have a better chance of living out.(Sarah)

> I kept going through my mind that he [obstetrician] was going to say "No, we are not doing to induce you this week. We can't". And then I would have to go extra days and wait. I was ready to have this baby. I didn't want to wait any more. In a way I thought that was selfish and then in another way, that was really the way I felt and you can't change that, you know. (Tina2)

The informants who made these statements regarding being anxious to have the baby delivered, also expressed an opposing view of wanting to keep the baby inside of them.

> So with this labour, that's what my biggest fear is, like, it is alive inside me so why can't we just keep it inside there? (Sarah)

> I know enough that, that the baby, that if these non-stress tests are run and the baby is in a healthy environment, the baby is just as, if not better off inside me until term. (Tina1)

For the most part, the primary informants found the idea of early induction threatening, and preferred to protect the baby by carrying the baby to term.

> If he can wait, the baby can wait, I would rather wait instead of like, delivering it a little early and you have to have another test [amniocentesis for lung maturity]. Yeah, because if you wait until the maturity date then the baby , everything should be grown maturely. So that is what we would like to do. We would like to do anything which is natural. (Helen1)

> Right to the very end I was still unsure about going through with this [Induction at 37 weeks gestation] because I wanted to go to term. (Grace2)

The informants' hesitancy to want to deliver this child might have been based on their previous experience of giving birth to death. They might have associated delivery with the baby dying and therefore wanted to protect the unborn child by maintaining it within them. Sarah verbalized these concerns.

> But this time I don't associate labour with giving life. Like, it's associated with death. Like it's just, that's how it ends sort of thing. (Sarah)

For Sarah, delivery had been a particularly painful experience. Her infant was diagnosed antenatally as having anencephaly and so Sarah knew that the baby would remain alive while in utero but that death was inevitable with extra uterine life. It was this tragic experience that was affecting her perception of delivery in this pregnancy.

> Like I knew, I knew that it was, he was going to die. Like that was all there was to it. But he was still alive. And that is another reason why the labour part is so terrible in my mind. Because he was still alive while he was inside of me. Whether he, and I knew as soon as that, we had the labour, that he was going to die. So it is almost like, like you are committing murder or something [said very softly]. Like it sounds stupid but that is how I felt. (Sarah)

Due to the fact that informants became pregnant again soon after their loss, preparing to give up the fetus represented the end of being pregnant for many months.

> There is still part of me that still, I mean, I miss being pregnant too. I've been pregnant for so long I guess. (Grace2)

As previously discussed, informants became disillusioned with the occurrence of the stillbirth and their confidence in health care was shaken. Therefore, trusting in the medical care they received in the subsequent pregnancy became important. The main thing that was important to the informants was not the emotional support that the physician might provide, but rather that the physician be a competent practitioner who would ensure that the child survived.

> But my doctor is not really for emotional things [laughs]. I didn't really want that from him anyway. I don't want a doctor that is going to coddle me. I want somebody that I can trust and that I think is the most knowledgeable and whether

> his bedside manner isn't the best, like he is a lot better than he was. Like in the first pregnancy I never asked questions and he didn't give me any information and we just cruised on through. And in this one at least he is a little more compassionate. But he's still, but that's the way I like him. And I don't want to go there and cry every month to get over it. (Sarah)

Following the occurrence of the stillbirth, it was important to informants in the next pregnancy that the physician acknowledge their fear of recurrence.

> And I think the strange part about it was I couldn't find a doctor who could understand how concerned I was that it would happen again. The first family kind of doctor that I came across said "Well, these things happen and it won't happen again". And I was sort of left thinking "Well, I would rather be prepared for it happening again than to go about it as if it is not going to happen", you know. (Carla)

Mothering a Live Child

The birth of a live child was a significant event that marked the end of the pregnancy which followed the stillbirth.

The reaction of the informants to the birth of a live child was relief that the child was alive and happiness that they had been successful in producing a live child.

> Oh, I felt so happy. Very happy. And then they told me that, when I heard the baby's cry and also I felt so happy, and the baby seemed so normal and looked healthy to me too. (Helen2)

> Once she started to cry and she really hollered...that really made me feel very good. I thought the more she screamed, the better. That was great. ... I felt really good, you know. It's over with and everything. A little bit overwhelmed and, you know, disbelief maybe, just a tad. (Tina2)

> Relief, relief! We actually had something! (Rita)

Due to others indicating to Marie that she was responsible for the stillbirth occurring, Marie felt the success at delivering a live child proved that she was able to be a mother.

> I had really been put down a lot for what happened in the first pregnancy. And so I felt, I felt this was my, my, I don't want to say revenge, but, sort of my, um, I guess revenge maybe, I don't know. (Marie)

Postnatal Attempting to Replace

In the postnatal period informants had to accept the live child that they had delivered. Grace compared her child to other children in the nursery in her fear that something was wrong with her child.

> But I would go by, and they would tell you not to look at other kids, but you would go by these full term kids and their eyes were open and his were going [she squints her eyes closed], you know. I was just comparing and thinking, " Gee's you know, maybe he's not as healthy as everyone had said when they felt him and everything." (Grace2)

In the process of accepting the live child the informants had to differentiate the live child from the previous stillbirth. Ease of acceptance appeared to depend on the importance of the sex of the child to the mother. For many of the informants, the sex of the child didn't matter as long as it was a healthy baby.

> This doesn't really matter [the sex of the baby] ... we didn't mind, a boy or a girl is all alike. (Helen2)

> Both sexes are so dependent on you and they are so helpless and you would just be protective over both. (Tina2)

For Carla it was important that she replaced the male child that was lost with a male child for her husband.

> I didn't really care when I was pregnant with Randy whether it was a boy or a girl or not. I felt, in a way better that my husband ended up with the boy that he lost because he seemed to have been more involved with that baby than I was. Like seeing him and all that stuff. So it is like I sort of replaced the first baby with Randy for my husband... (Carla)

Grace wanted to mother a girl and lost this opportunity when her female child was stillborn. Although she delivered a healthy male infant, she still longed for the female child that was lost.

> I wish that, that he was her, you know. ... I am glad he is here but I still wish I had her...I was thinking it is all the girl things that I would do with her, you know... part of those things aren't there with him. (Grace3)

Interestingly, Helen expressed this same desire to be the mother of a girl infant but readily accepted the role of being a mother to a boy once she saw her son.

> I sometimes, at the beginning, I thought I would like a baby girl better... Since I saw this little guy I don't mind. Yeah, it is the same to us. It is the same. (Helen2)

Grace felt that having a child of the same sex would have made acceptance of the new child easier. At the same time she realized that she would have been more likely to consider the live child as a replacement for the stillborn child if they had been the same sex.

> I don't know how I would have related if it was a girl, but I think at times, I think it might have been easier in a way to have a girl. I don't really know, like, I, just because of the way I have been feeling now. And then again I'd probably be putting more on it because she was a girl too, in some sort of a weird way or maybe it's not so weird, I'd always be looking at her like maybe this is Jane back again. You know, maybe it is her coming, you know, whatever your beliefs are in reincarnation or whatever, and maybe I would be, I don't know, it's hard to say. (Grace3)

Despite the presence of the live child, informants came to realize that this child did not replace the child that was lost.

> I don't think of it [previous loss] a whole lot or anything. It has certainly crossed my mind and I wish that I could change things and have that other one. I always will. (Tina2)

> I will look at him and just sort of think back on what she looked like. I'll be sitting around sometimes in the evening and I will just start to cry and say that I just want her too, you know. I don't know, there is still that emptiness too. Like even though he is here. (Grace2)

In differentiating the live child from the lost child, Grace struggled with the question of why one child had survived and one child had not. This may have been connected with Grace's unresolved self blame over the occurrence of the stillbirth.

> I just sort of rationally say "Well, he's just, maybe he's stronger and he can take it". And almost "Why couldn't she?... Why didn't she, why couldn't she handle the stress?" (Grace3)

Grace recognized that this child wouldn't exist if the other child hadn't died.

> If that hadn't have happened to their first one they wouldn't have this one, do you know what I mean? Because he was only conceived two or three months after her... (Grace2)

Postnatal Fearing Recurrence

Although with the birth of the live child the mother's fears of having another stillbirth were resolved, fearing recurrence of loss was carried into the postpartum period.

> There is a big relief. There is a definite relief but I haven't really gone [gives a big sigh of relief]. You know because I was so worried about him. Is he going to be mentally and physically OK? Like, you know. How is he going to come out? (Grace2)

Grace's fear of recurrence which continued after delivery delayed her feeling happy and confident about her new son.

> I wasn't really in that celebration mood once the baby was born ... I was really worried and wondering if this baby's OK, you know. Are they telling me everything? ... In the back of my mind in a way that I would kind of think that something was going, something is or could have gone wrong to the, the whole time. ... Part of me wasn't allowing myself to feel happy. I was sitting there thinking "Well, maybe something is going to go wrong" because of past history too or... (Grace2)

Grace's son developed hyperbilirubinemia and Carla's son was born prematurely. The threat to their infant's wellbeing probably fostered the informants' fear of recurrence. In Carla's case, there was a definite possibility that her son's life was in jeopardy while in

Grace's case the neonatal jaundice was a minor physical problem. Despite the differences in the possible consequences to the infants' welfare both mothers reacted the same. Both mothers were afraid that perinatal loss would recur and despite reassurances from the medical staff, were not convinced that their child would survive until the physical problems were resolved.

> And just, now, everything cleared up so well but I had to see that, again, for myself, for him to come out of it. (Grace3)

> I guess there was always this, this thought, or this fear that I was going to go to the hospital this one day and he wasn't going to be there any more. Even though the doctor said he was fine. (Carla)

Postnatal Resisting Attachment

Even prior to her son developing jaundice Grace wanted passive interaction with her baby. She wanted to know that the baby was alright but she did not want to be actively involved.

> OK, he's been on my tummy but take him away. Not take him right away , but just let somebody else hold him or do something with him. (Grace2)
> I had asked Bill to go and get him before I went to bed, just so, so I could seen him before I went to bed. And he wheeled him down and everything. And I just said good night. I didn't hold him or anything like that. I was just sort of looking at him in bed, I didn't feel like picking him up then. (Grace2)

It took Grace until two weeks postpartum to be confident that her son was going to be alright. She started to feel confident once the jaundice was resolving and once she was past her due date.

> I had people phoning me in the hospital "Oh Grace, I am so happy. Congratulations da da da da". And I'm going "Yeah, but he's got," and I was talking about his health. [laughs] I wasn't saying "Oh Gee's, yeah, thanks, it's so nice and I'm really happy". ... I wasn't hugely ecstatic and I think now once I, yesterday [two weeks postpartum] was the first day I picked up the phone long distance. I was really feeling good about him and started to feel really happy because he's just a healthy, he's gaining weight and doing what he should be doing. (Grace2)

Grace recognized the resistance to attachment she was feeling and felt guilty about this.

> I wasn't really in that celebration mood once the baby was born and I almost starting feeling guilty about that. ... There was a bit too that guilt too because you hear all this bonding bit and this is the way you should be doing, and doing this breastfeeding. (Grace2)
> Sometimes I feel like I am distancing myself a little bit from him [pause]. But then again, I, I, [pause] I tend to think that I try, like, I try to make it up in other ways, sometimes, I, I, I don't know. There is something there. (Grace3)

Unlike Grace and Carla's experiences, the other nine informants expressed more immediate attachment to the liveborn child. Helen felt confidence in her son's wellbeing as soon as he was born and expressed her love for him.

> Even before I saw him I already loved him. ... But to me, maybe I already had very good confidence. It seemed that my baby was so strong and healthy. I didn't wait that long. The first minute I saw him I was quite, I was quite happy already. I was quite confident already, yeah. (Helen2)

Postnatal Protecting

Protecting the child was important in the intrapartum period when fearing recurrence was extreme. Tina was relieved that the nurse who cared for her during labour had the knowledge and skills to protect her baby.

> I had an excellent nurse and she gave me oxygen and on my right side. ... I don't know whether the nurse knew that I had had a stillborn... she was an exceptional nurse. I was lucky. I am sure not all nurses are like that. They, she was extremely expert at it, what she was doing.(Tina2)

Just as fearing recurrence carried on into the postnatal period, so did protecting the child.

> Maybe I was looking at him as being fragile or maybe I would have been overprotective anyhow. I am not to sure. I think when the jaundice thing came and everything, that's when I sort of panicked and blew it all out of proportion not knowing once again what this whole thing was about and thinking "Oh God, is something happening to this one too". (Grace2)

For Lucy, the feeling of protection had lasted over thirty years.

> Because, when she was born she became very jaundiced and she was two ounces over incubator weight at the time. And I still feel to this day that she should have been placed in an incubator. And, so I think you really worry about them once you have lost one. You don't want anything to happen to this one. (Lucy)

It took the informants a while to adjust to the new baby and to feel confident in the mothering role.

> I mean I don't have my total confidence up yet about taking him in, I mean I guess I could. I haven't, it's coming but I don't know if I have my total confidence up about being out in pubic, about doing things [six weeks postpartum]... It is still going to take some time with all of us. (Grace3).

Acknowledging the Lost Child

The birth of the live child rekindled the grief over the lost child.

> I think I remember the degree of my loss, like it is such a precious thing. Like that can be easily forgotten or overlooked over a period of time. You do forget a little, you know, about the value and you kind of see this little bundle of joy here and you remember that you had one before too. (Tina2)

> I think about Jane more so now. I'll be looking at him. It's hard, because I did, in the hospital I was upset again. ... I just had certain things that, yeah, I was carrying still with me about her. I think it's more so now that I am upset about her. ... I will look at his face and sort of try and remember her too. He is so here and when I shut my eyes and try to picture her I can sort of see her and I'll look at little things on him and stuff. (Grace2)

In Grace's comments it appeared that grieving for the lost child had been delayed by the subsequent pregnancy and then was rekindled with the birth of the live child.

> I have been more upset about Jane than I was at the beginning, you know. Because I was so absorbed and worried about this pregnancy when I was pregnant at the end. When I got home, yeah, I'd sometimes bake and stuff, but lately it seems that I've had periods that I have been upset about her. (Grace3)

When asked about this, Grace denied that the subsequent pregnancy altered her grieving process.

> I would never suggest or say, well, you should wait or you should do this. You should just go for it. In a way I don't think if I waited a year or two years, I think I would still have a lot of what's going on. ... After, like after the death of her, if I had to wait a couple of years or something to get pregnant, I think I would go through quite a few of the same, similar things that I went through with him. And after, and after he was born too? Yeah, I think so. You know, I

think that you would. (Grace3)

In congruence with accepting the live child, there was a need among the informants to acknowledge the lost child. Informants did not want to negate the existence of the lost child with the existence of the live child.

> And I think there is still that thing, "Is this your first child?" Like I am still conscious of people saying, someone wrote me a letter, we went to a shower up where I worked, Allen and I on Thursday and someone said "Oh congratulations to your first born son". And I thought, I really hung on to those words, I was really glad she said your first born son, like, it's not your first baby. (Grace3)

Grace acknowledged her stillborn child by attending a parent support group for those who had experienced a perinatal loss.

> I feel so guilty when I am not going because when I am going, that to me was something that I was doing for Jane too, and for myself. ... Because if I stop then I have just cut myself away from her, like, because I think a lot of people do end up going to sometimes these things to keep that, the name, honour of the person on. ... And, then, as I say, it kind of keeps me going because I can think about her.(Grace3)

Informants continued to acknowledge the stillborn child years later.

> I think the point is that baby will always be a part of our family and rather than be a secret, that baby should be a part of our family. (Carla)

> And since we have lived in so many communities when ever we go back to that area we always go up and take a look at the grave and tidy up a bit and so on. I mean, that is about all you can do. (Lucy)

Informants faced the task of telling the live child about the stillborn sibling.

> He [husband] asked me "When he grows up will I say anything to Allen [the baby] about her?" And not to go way overboard, he's saying, but "Will you let him know?" And I am saying "Yeah, yeah", you know. (Grace3)

> And then you decide when should you tell this one, this one, that his brother died. And you know, you do think about that. (Sarah)

For two of the informants there was a perception that the lost child remained present in a sense and continued to influence their lif[illegible]

> I feel like the baby that died is my guardian angel and anything that goes right in my life I always think that it is him pulling strings for me. (Marie)

> When we see a rainbow we know that's Melissa. ... She is looking after us. (Rita)

In caring for the live child, the mothers were faced with sharing between the stillborn child and the live child. The nursery, articles of clothing, intrauterine space, and maternal love were recognized as being things that were shared between the two offspring.

> Like sometimes I think to myself "You are in the same space that that baby was in. You are in there where he was, you know". It is like being in the same house as somebody.(Marie)

> If I ever thought that my sadness over losing the first baby would affect Randy, and Randy thinking "Well, you don't love me because you love that other baby more" or whatever, I would die. (Carla)

> I was wondering if I would have as much love or as much care for this baby or the next baby as I did for her. ... Wondering if they have enough love to carry over for the next one. (Grace3)

That nursing staff acknowledged the lost child in this pregnancy was important to informants. Informants appreciated when nursing staff recognized their concerns antepartum and intrapartum and provided additional support.

> I think I am uptight about it now, you know, and every time I go for the fetal stress tests I start to get into hot sweats [laughs] and stuff too because I am so anxious again, you know. But they've [nurses] been OK. They come in and talk to me and that. (Grace1)
> So that was labour. They [nurses] were all helpful and everything. I mean, they were really nice... (Grace2)
>
> And she [social worker] said, she told me that the nurses asked her how I was doing and if I was coping OK and they were quite concerned and stuff. And I remember thinking that that was just wonderful of them. That I had come through this and I had a live healthy baby and they were still concerned about me. So that was really good. That was really nice. (Marie)

Three of the informants did not perceive that they received the assistance and support they required in the postpartum period. They felt that the postpartum staff did not acknowledge that the first child had died, and assumed because of their parity that they were competent and confident in the mothering role.

> They had on my records that this was my second. And I guess maybe for medical reasons they need to know that but, as far as any help or anything I guess they assumed that I knew everything and I knew nothing. ... I really felt neglected in the hospital. ... I just didn't feel like I was getting a hell of a lot of support.(Grace2)
>
> Well, as far as nursing care goes, I don't think that when I had Randy that the nurses were even aware that I had had a baby. Well, I would imagine

> it says under, those things 1, 0, 1, or whatever... That Randy was baby number two and that baby number one wasn't alive any more just by the numbers that they write down. (Carla)

Perception of Others

The perception of others is a category which pervades the entire experience and so is included at the end of the research findings. Informants were very conscious of how other people might perceive their situation. They often commented that their experience was different from what other people might think. There also might have been dissonance between the informant's experience and their own expectations of what the experience might be like.

The informants recognized that other people did not understand the significance of their loss.

> Because they figure that, because you weren't actually bringing that child up that you can't miss it. Or miss the whatever. They don't understand that [sighs] having it growing and feeling the expectations, you know. Wanting to be that mother and then all of a sudden, nothing. They don't understand the attachment you felt. They say "Oh well, it just wasn't meant to be". They said that! (Linda)

> And his mother's belief for our first baby was that he wasn't a baby because he died in utero and I never got to hold him and I never got to change his diapers and nurse him or whatever. So he wasn't a real baby. And she said to my face " You are not grieving for a real child. You don't know what it is like to have a real child". (Marie)

The informants even thought that their husbands could not understand their loss.

> I get the impressions that Larry didn't realize exactly, you know, because he is a husband he

> doesn't, he's a man and he doesn't know what a woman feels about her baby or whatever. (Tina2)
>
> A man could never understand. My husband, he lived through it, and my husband can't even understand what I went through. Because ... to him it was like, you know, it wasn't something alive yet. Like when it laughs and crawls on the floor and stuff like that, I think that is when men get more... (Sarah)

Grace was resisting attaching during labour and delivery and postnatally in this pregnancy. Others did not realize this and mistakenly assumed that Grace would be ecstatic to become the mother of a live child.

> I can't really say I was excited during the whole thing, I mean, you know, because I had a few nurses I knew up there [caseroom] already, and people saying "Well, now, it's going to happen. You are going to have a baby tonight" and all this. I wasn't getting really ecstatic or thrilled . It seemed the people around me were more excited about it than I was. ... And I almost started feeling guilty about that, you know, you hear everyone else being ... I sound like a morbid person but everyone is so excited when the baby is born. (Grace2)

Others mistakenly thought that the grief over the stillbirth would be immediately resolved with the birth of the live child. They assumed Grace would no longer have a need to be involved with the Parent Support Group.

> One of the girls said "Well, do you still want your name on the brochure, your number given out?" And I thought "yeah, yeah". Like it was just after he was born. I don't know if they thought...(Grace3)

They failed to realize that once stillbirth occurs, it changes a woman's life forever.

Summary of the Process of Livebirth Following Stillbirth

The critical juncture in the process of livebirth following stillbirth is the occurrence of the previous stillbirth. In order to fully understand this process it is necessary to go back in time to consider the antecedents to the stillbirth. The informants were transforming to motherhood. The occurrence of stillbirth interrupted this process. The informants' worst fears were realized when the stillbirth happened to them. They not only experienced the loss of their child, but also the loss of the mothering role, a loss of control, and a loss of confidence in their own ability to produce a live child.

For women who were pregnant for the first time since having a stillborn baby, the themes of replacement of the mothering role and to a lesser extent the lost child, were dominant. In the early stages of pregnancy the lost child and the current unborn child became fused. Some differentiation occurred following fetal movement and ultrasound but separation of the two was not complete until after the birth.

The second major theme was fear of loss of this child. The fear of loss was not just a fear of the recurrence of stillbirth but rather was a fear that anything untoward would happen to this child. This fear of recurrence of loss also occurred with informants who had had a live birth subsequent to the stillbirth. This fear appeared to influence attaching behaviours. Early in pregnancy the mothers delayed telling others about the pregnancy. Mothers with no previous live children did not fantasize about the unborn child . They avoided personalizing the child: they did not want to know the sex of the unborn child and they did not want to chose a name for the child. Later in pregnancy the mothers did not select baby clothes or prepare a nursery. The mothers recognized their hesitancy to attach to their child and felt guilty about this. Hesitancy to attach to the unborn child seemed to decrease once quickening occurred, once the fetus was viable, once the gestational age at which the previous loss had occurred was past, and generally with time.

Protective behaviour was evident, mothers adapting their lifestyle (for example, eating, or giving up work early) if they believed it to be beneficial for their unborn child. When they talked to the baby there was evidence to show that they spoke about efforts they were making to care for the child. The mothers did not want information on growth and development of the unborn child but they did want information about fetal wellbeing. As labour approached they expressed concern that the unborn baby was safer inside than being born. They had many concerns about induction of labour and found this threatening. Informants felt relief when the baby was born. With the birth of the live child they felt success at having fulfilled the mothering role.

Following birth the mothers appeared to complete two tasks: acknowledging the stillborn child and becoming acquainted with the new baby. Through this process differentiation of the newborn from the stillborn baby took place. The fear of recurrence of loss did not appear to dissipate with the live birth, the mothers expressing high levels of anxiety over minor health deviations such as an elevated bilirubin level. Two mothers who had babies with problems (neonatal jaundice and prematurity) continued to resist attaching. The other mothers seemed more confident in their acceptance of the baby. Birth of the baby rekindled grief as mothers recognized that the live child would not replace the child they had lost. Putting the child in the nursery and clothing that were meant for the child that died precipitated their grieving. In addition, the presence of the live child made the mothers more aware of the value of the child that was lost.

A schematic model of the process that was identified follows.

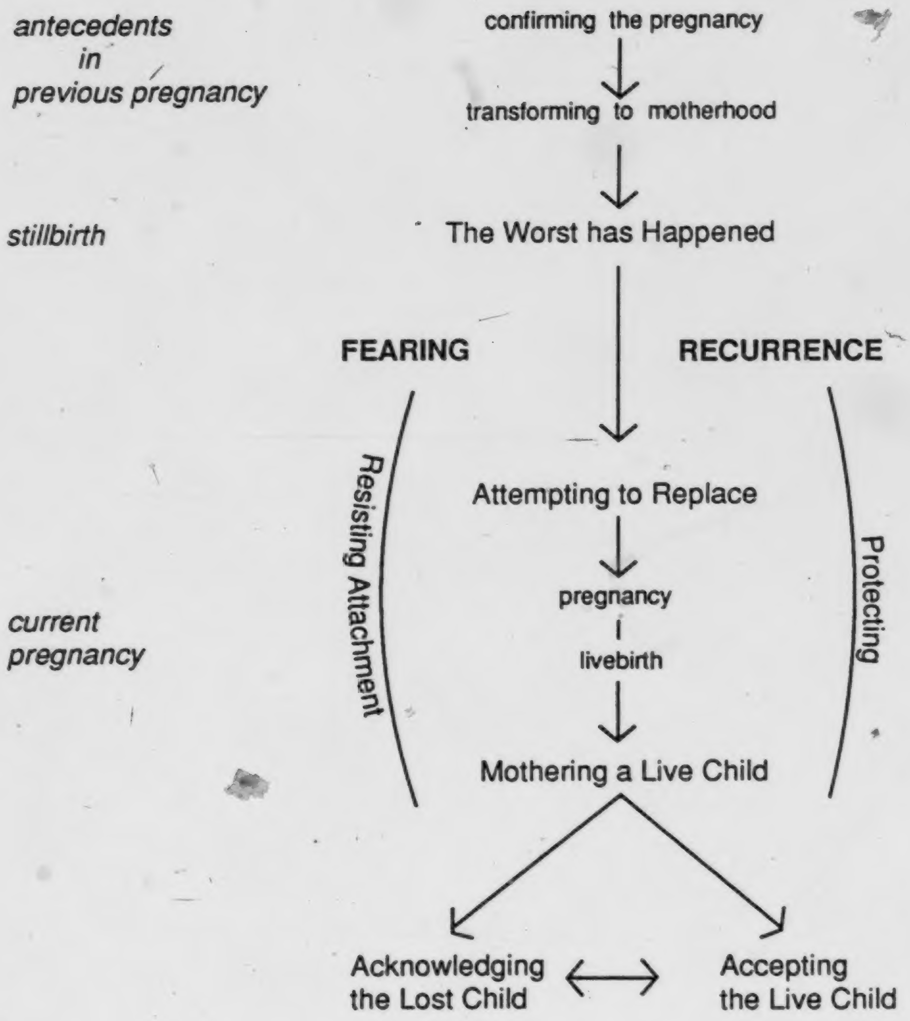
antecedents
in
previous pregnancy
confirming the pregnancy
transforming to motherhood
stillbirth
The Worst has Happened
FEARING
RECURRENCE
Resisting Attachment
Protecting
Attempting to Replace
pregnancy
livebirth
current
pregnancy
Mothering a Live Child
Acknowledging the Lost Child
Accepting the Live Child

Figure 1: The Maternal Processes of Livebirth Following Stillbirth

In this chapter, the process of livebirth following stillbirth as derived from the experiences of the 11 women who participated in the study was presented. Dialogue from the interviews was included where appropriate to illustrate the steps in the process and demonstrate how the process was derived.

Discussion of the study findings and the relationship between the findings and the current literature on attaching behaviour and perinatal loss are included in the next chapter. Implications of this study for nursing practice and further nursing research are also included as are propositions based on the findings of the study.

Chapter V

DISCUSSION AND IMPLICATIONS

Introduction

The purpose of this research was to identify and describe perinatal maternal processes that occur with livebirth subsequent to stillbirth. The theoretical model that was generated represents these processes which occur in livebirth after stillbirth. Central to these processes is the informants' development of a relationship with their unborn children and their live children following birth.

Discussion

The 11 informants who participated in the research study did go through a similar process with identifiable characteristics. The informants reported similar reactions to the loss; their worst fears were realized with the occurrence of the stillbirth. For all the informants the occurrence of the stillbirth led to a fear of recurrence of loss which was pervasive in the subsequent pregnancy and continued into the postpartum period.

In analyzing the data it is important to note that the information contributed by informants was collected antenatally and in the postpartum period. The experience of the informants was related by them in the context of the current pregnancy.

The terms attachment (Ainsworth, 1969), bonding (Klaus & Kennell, 1976) and maternal-infant interaction (Funke-

Ferber, 1978) have been used in the literature to indicate the process of a mother coming to know her child. As the research was limited to investigate the mothers' perspective only, the terms were not defined at the outset of this research. Informants used such terms as closeness, bonding and love when talking about developing their relationship with their unborn children antenatally and children postnatally. When informants spoke of establishing their relationship with their children they most often used the word "bonding", a term popularized in the 1970's and used extensively in the lay literature (Klaus & Kennell, 1970).

The results from this study indicate that although informants did develop a relationship with the fetus antenatally in the current pregnancy, they were hesitant and delayed in performing many of the described antenatal tasks of attaching. Hesitancy to develop a relationship with the child postnatally occurred as a consequence of fearing recurrence of the loss of the child. This was particularly so if the informants perceived any threat to the child's wellbeing such as prematurity or hyperbilirubinemia.

The theoretical model, the steps and influencing conditions, are discussed in this chapter. A comparison is made between the findings from this study and the knowledge currently available in the literature in the areas of prenatal and postnatal attachment and perinatal loss. Discussion of the model is followed by implications for nursing practice, indications for further nursing research, the strengths and limitations of this study, and propositions based on the research findings.

Theoretical Model: Steps and Influencing Conditions

Antecedents in the Previous Pregnancy:

An assumption in this research study was that the informants were in the process of transforming to motherhood (Bergum, 1989; Raphael-Leff, 1982) when the stillbirth occurred. It was further assumed that prior to the stillbirth the informants were accomplishing the recognized antenatal tasks of attachment (Cranley, 1981a: Leifer, 1977; Lumley, 1980a; Rubin, 1975; Stainton, 1985a, 1985b, 1986).

The Worst Has Happened:

The occurrence of stillbirth was devastating for the informants. They had not anticipated that such a tragic thing would happen to them. Suddenly with the unexpected death of the child, transforming to motherhood was interrupted. There was no child to mother. As outlined by Davidson (1977), the informants' hopes and dreams were lost with the death of their child. The two alternate informants whose children lived a few days, reported the same reaction as those informants whose unborn child died before birth. This supports the work of Peppers and Knapp (1980a,1980b) and Wolff, Nielson, and Schiller (1970) who reported that the grief reactions following miscarriage, stillbirth and neonatal death are similar. The loss shattered the informant's faith in their own ability to produce a live child and they became disillusioned with the health care system. The informants felt vulnerable.

Attempting to Replace:

When the transformation to motherhood was interrupted by the occurrence of the stillbirth, the informants described how they felt empty and cheated and desperately wanted a baby to mother. They had a desire to become pregnant immediately to replace the child that they lost, which is a similar reaction to that reported by other researchers (Cain & Cain, 1964; Kennell & Trause, 1978; Kirkley-Best & Kellner, 1982). Although it is recognized by health professionals that waiting a period of at least 12 months is desirable for the mother to recover both physically and emotionally from the stillbirth (Forrest, Standish & Baum, 1982; Lewis, 1976, 1979b; Lewis & Page, 1978; Pozanski, 1972; Rowe, Clyman, Green, Mikkelson, Haight & Ataide, 1978), eight of the 11 informants were pregnant again by the sixth month. This short pregnancy spacing following stillbirth has previously been documented in the literature. (Bourne, 1968; Forrest, Standish, & Baum, 1982; Rowe et al., 1978)

The experience of stillbirth is unique, in that it is a situation where the mother has developed a relationship with the fetus but has not had an opportunity to develop a relationship with the live child. In the previous pregnancy the informants' relationship with their unborn child had been based on their antenatal interaction with their child, their perception of movement (Arbeit, 1975), seeing the child on ultrasound (Kohn, Nelson, & Weiner, 1980; Milne & Rich, 1981), hearing the baby's heartbeat, and fantasizing what their child would be like (Rubin, 1975; Tanner, 1969). Their postnatal knowledge of their child was limited to viewing and holding the dead child. Seven of the informants were deprived of this knowledge because they were denied the opportunity to see and hold their baby.

In stillbirth the chance of coming to know that child as a unique individual with it's own personality is restricted. Based on the data it seems probable that this limited knowledge of the lost child made attempting to replace that child easier for the informants. Although Davidson (1977) and Harrington (1982) make brief references regarding coming to know the stillborn child in the process of grieving, no literature was found that considered the effect of the relationship with the stillborn infant and how this relationship affects the relationship developed with a child in the next pregnancy.

A recognized step in the grieving process is coming to accept that the loved person no longer exists (Engel, 1964; Parkes, 1970a). Following stillbirth, becoming pregnant again provided a unique opportunity for informants to replace a human being that no longer existed. Each informant created a life in attempt to replace the one that was lost. In becoming pregnant again, each informant's relationship with her unborn child was again built on her perception of movement, seeing the child on ultrasound, and hearing the baby's heartbeat.

Informants who had not previously had a live child hesitated to fantasize about the child in this pregnancy. Therefore, the relationship the mother developed with this unborn child was similar to the relationship she had had with the previous eventually stillborn child. In addition, the short time frame between the pregnancies contributed to the challenge of differentiating between them. As recognized by Lewis and Page (1978), fusion of the pregnancies facilitated the mother's antenatal perception that this unborn child replaced the lost child.

Fearing Recurrence

Fearing recurrence is the core variable in the process of livebirth following stillbirth. It appears to be the basic social psychological process which distinguishes pregnancy following perinatal loss from other pregnancies for the informants in this study. While all pregnant women recognize the possibility that something untoward could happen to their child (Brazelton, 1963; Rubin, 1975), this threat to the child's wellbeing is remote. For informants who had a previous stillbirth the threat to their child's wellbeing was based on their previous experience. The threat was no longer remote but was perceived as something that could happen to them (Mandell & Wolfe, 1975). Fearing recurrence might also have been facilitated by the particular relationship that existed between the mother and the unborn child. If the child was conceived as a replacement for the stillborn child, and if indeed there was a perceived fusion of the children, the mother was more likely also to perceive that the outcome might be the same.

The antecedent to fearing recurrence was the occurrence of stillbirth. Once perinatal loss had happened, the informants felt vulnerable, but it was confirmation of the next pregnancy that fostered fearing recurrence. It was then that there was a tangible infant to be lost. Fearing loss was not only pervasive in the pregnancy but also carried on into the postpartum period.

Fearing recurrence manifested itself as anxiety. Many authors have recognized the anxiety that is present in pregnancy following stillbirth (Jolly, 1976; Lewis 1980; Penticuff, 1982; Phipps, 1985). Anxiety became more pronounced toward term (Phipps, 1985). Informants were surprised at how overwhelming their anxiety became. For some informants the anxiety was so extreme it was nearly incapacitating.

Two consequences of fearing recurrence emerged: 1) resisting attachment to the fetus for fear that the child would die and the informants would once again experience the devastation of stillbirth, and 2) protecting the fetus in an attempt to ensure that the fetus and live child survived intact.

Resisting Attachment

As a result of the informants' fear of recurrence the informants delayed completing many of the tasks of attachment which are normally accomplished antenatally. This supports the work of Cranley (1981b) who reported that perceived stress had a negative association with attachment and Avant (1981) who reported that highly anxious mothers had low attachment scores. Stainton (1981) also reported that mothers who had previously lost a child had reduced scores on a measure of attachment postnatally. Phipps (1985) used the term "suspension of commitment to pregnancy" (p.248) to describe resisting attachment .

While Lumley (1980b) reported that 70% of low risk women interviewed in the first trimester reported unreality associated with pregnancy, this number decreased to 37% in the second trimester and to 8% in the third trimester. All the informants in this study were slow to accept the reality of the pregnancy, two primary informants speaking of unreality even beyond 36 weeks gestation. Phipps (1985) recognized that in subsequent pregnancy following stillbirth women conceal the pregnancy as long as possible. The data in this study supported Phipps' findings, the informants delayed telling others that they were pregnant until they were well into the second trimester. Two of the recognized tasks of pregnancy are a gravid woman fantasizing about the coming child (Brazelton, 1963; Tanner, 1969) and fantasizing about herself in the motherhood role (Cranley, 1981b; Raphael-Leff, 1982; Rubin, 1967). In the pregnancy following the stillbirth the informants who did not have a live child resisted fantasizing about the coming child and resisted fantasizing about themselves in the motherhood role (Phipps, 1985). This task was more easily accomplished by the informants who had a live child as they had experienced the mothering role (Lumley, 1980a). In this study, informants who had a live child and were able to fantasize about the expected child were more likely to view the stillborn child as a separate baby that could not be replaced.

Another recognized task of pregnancy is preparing for the child (Cranley, 1981b; Leifer, 1977; Rubin, 1975; Tanner, 1969). Informants did not plan for the coming child and none prepared a nursery (Lewis, 1980; Phipps, 1985, Wilson, Soule, & Fenton, 1988).

Interaction with the unborn child (Carter-Jessop, 1981; Cranley, 1981b; Rubin, 1975; Stainton, 1985b) and recognition of the individual characteristics of the child (Cranley, 1981b; Stainton, 1985b, 1986) are two tasks of binding-in in pregnancy in which these informants were hesitant to partake. Resistance to attaching to the unborn child was decreased following quickening, following the anniversary of the gestational age where the loss occurred in the previous pregnancy, following viability, and generally with time. In a study of women who were pregnant again following miscarriage, Bodnar (1985) reported a decrease in resistance to attachment following the anniversary of the gestational age where the loss occurred.

Protecting

Due to the informants' fear of recurrence in this pregnancy, protecting the unborn child was important to them. As a result of this intense desire to protect the fetus from harm, four of the tasks of pregnancy were emphasized: 1) recognizing fetal movement (Lumley, 1980a, 1980b; Rubin, 1975; Taylor & Hall, 1979; Tanner, 1969), 2) giving of oneself (Rubin, 1975), 3) preparing to give up the fetus (Rubin, 1975; Tanner, 1969), and 4) seeking safe passage (Rubin, 1975).

The results from the study support the findings that developing awareness of the unborn child and attaching to the child is a process that occurs over time (Cranley, 1981a; Lumley, 1980a, 1982; Zachariah, 1985, Stainton, 1985b). Quickening has been recognized as an event that facilitates attaching antenatally (Lumley, 1980a; Rubin, 1975; Taylor & Hall, 1979). Indeed, quickening was a significant event for the informants. With the occurrence of quickening, resisting attachment became more difficult. Fetal movement made the mothers aware of the presence of the child.

Fetal movement was also important to the informants as its presence indicated fetal wellbeing (Phipps, 1985). It was commonly the loss of fetal movement which previously had indicated fetal demise to the informants. Therefore monitoring fetal movement had important implications for the informants in relation to their fear of recurrence. Although the relationship between the unborn child and the gravid woman was one of a closeness unparalleled in any other relationship because of the embodiment of the child by the mother (Stainton, 1985b), the only indicator the mother herself had of fetal wellbeing was her perception of movement.

Giving of self is a recognized task of pregnancy (Cranley, 1981b; Rubin, 1975). In order to protect the unborn child, the informants willingly gave of themselves. It was not uncommon for informants to be obsessive about eating nutritiously, resting, or giving up work. The informants' efforts in giving of self were often focused on whatever the informant felt had contributed to the occurrence of stillbirth. Giving of self provided the informants with an active approach to dealing with their fear of recurrence.

Another recognized task of pregnancy is preparing to give up the unborn infant (Rubin, 1975). As the previous birth had ended in giving birth to a dead child, the informants delayed in preparing to give up the unborn child and preferred instead to keep the child in utero where they perceived it to be safe. Informants viewed induction and labour and delivery as a threat even at term. In contrast, if an informant perceived that the child was unsafe in being inside her, then she was prematurely prepared to give up the child during the second trimester.

A fourth task of pregnancy that was emphasized in women who had previously had a stillbirth was seeking safe passage (Rubin, 1975). Informants' interest in information regarding growth and development of the child was only in regards to reassuring them of fetal wellbeing. Antenatal screening provided reassurance of fetal health. Informants were hesitant to partake in screening procedures such as amniocentesis and oxytocin challenge testing where there were risks to the unborn child. Informants sought antenatal care from a physician whom they could trust.

Mothering a Live Child:

With the birth of a live child, informants experienced relief. Following birth resistance to attachment ended abruptly or gradually. It appeared that for the informants, resolution of resisting attachment depended on their confidence in the health of the newborn child and the degree of fearing recurrence which persisted postnatally. One of the recognized tasks of pregnancy is a compulsive need to ascertain that the baby is whole and intact (Rubin, 1961).

This task assumed increased importance for the informants who previously had a stillbirth and were fearing recurrence. With the birth of a live child, fear of recurrence of stillbirth was resolved but informants continued to fear something else untoward happening to the child. When the child had any physical problems, informants fear of recurrence of the loss was not resolved and therefore, resistance to attachment was more likely to persist. Brady-Fryer (1988) reported that mothers of premature infants took time in the postnatal period to forge a role as the mother of a high risk infant. Although delay in postnatal attaching in some women following stillbirth has been reported in the literature (Phipps, 1985; Seitz & Warrick, 1974; Stainton, 1981) the relationship between a mother's concern over the physical condition of her infant and the resolution of resisting attachment has not previously been documented.

Nesting behaviour that had been delayed in the antenatal period became important once the child was born. Preparing for the child occurred as resisting attachment decreased.

Informants tended to be overprotective of the infant postnatally (Phipps, 1985; Pozanski, 1972; Raphael-Leff, 1982; Wilson, Soule, & Fenton, 1988). Informants were slow to develop confidence in the mothering role. This finding supported the work of Gojmerac (1988) who reported that parents' sense of competence gradually rose over time and that parental anxiety resulted in a delay in competence. Informants highly valued having a live child and the opportunity to be a mother, but were still anxious, fearing illness or neonatal loss.

One of the postnatal tasks of attaching to a child that has been recognized in the literature is differentiating and accepting the live child from the fantasized child (Ludington-Hoe, 1977; Mercer, 1981a; Rubin, 1977). As previously discussed, these informants were hesitant to fantasize about the live child antenatally (Phipps, 1985). Due to their fear of recurrence and fuelled by the fusion of the two pregnancies, they had difficulty believing that they would successfully deliver a live child, but rather that this child too would be dead at birth. It would appear that for the informants who had experienced a stillbirth, the fantasized child was the dead child. A task that occurred postnatally was to differentiate the live child from the stillborn child. The informants had to resolve their fear of recurrence and come to accept that the live child was different from the stillborn child and that this child would not die.

Acknowledging the Lost Child:

With the birth of a live child, the desired mothering role was fulfilled. The presence of the live child facilitated differentiation of the live child from the dead child. The mothers realized that although they had become mothers, the live child could not replace the child that was lost. Mothering the live child facilitated this differentiation; putting the live child in the nursery that was meant for the other child and putting the live child in the clothes that were meant for the other child . Although Walz and Rich (1983) and Rubin (1967) identified that mothering a second child required differentiation, they were discussing the differentiation that must occur with the birth of a second live child in the postpartum period. No literature was found which recognized the postnatal differentiation that occurs with the birth of a live child following a stillbirth. Differentiation was made easier if the live child was a different sex from the child that was lost.

The findings supported the work of several authors who reported that the presence of the live child rekindled the mothers residual grief (Lewis, 1976; Phipps, 1985; Rowe et al, 1978; Seitz & Warrick,1974). It is known that the grieving process takes an average of six to 12 months (Richardson, 1974; Reed, 1984). With the occurrence of pregnancy in a few months following the stillbirth, the informants had little time to grieve for the infant that had died. Once the pregnancy was over and the mothering role had been fulfilled, and with the occurrence of differentiation of the live child from the dead child, the informants recognized the value of the child that was lost and resumed their grieving.

It was important to informants to acknowledge the differentiation of the two children so that the importance of the stillborn child was not negated. Again, the data is supported by the work of Walz & Rich (1983) who reported that one of the maternal tasks which occurs postnatally following the birth of a second child is resolving the loss of an exclusive dyadic relationship with the first child. In the case of livebirth following stillbirth, differentiation of the live child from the child that died and acknowledgement of the death was perhaps an important step that had to be accomplished in order to establish a healthy relationship between the mother and her newborn infant. Lindemann (1944) and Pozanski (1972) recognized that withdrawal of emotional attachment from the deceased was important in order to allow formation of new relationships.

Grief for the stillborn child was not resolved with the birth of a live child. Grieving was sustained over time. Informants verbalized that grief for the child they had lost would always remain with them. The informants' grief was emphasized annually on the anniversary of the loss. This supports the work of Morgan (1987) who reported that following neonatal death remnants of grief remained even five years following the loss.

Even after informants had successfully delivered a live child, fearing recurrence recurred in additional pregnancies. Once stillbirth occurred, fearing recurrence was triggered and would remain every time the women were pregnant.

Based on the findings of this study, it is hypothesized that fearing recurrence would be present following any perinatal loss. Following experiences such as miscarriage, stillbirth, neonatal death, premature delivery, or congenital anomaly, fearing recurrence would be present in the next pregnancy. Indeed, it is probable that any time an individual is violated, be it by rape, robbery, fire, or similar traumatic events, fearing recurrence would prevail as a consequence.

IMPLICATIONS FOR NURSING

It was apparent that in livebirth following stillbirth, fearing recurrence results in resistance and delay in accomplishing many of the antenatal and postnatal tasks of attaching while other tasks of pregnancy are enhanced by the fear of recurrence. What must be determined is whether this delay in achieving the normal milestones of pregnancy was pathological or an adaptive means of coping. It would appear that the fearing recurrence which occurred following stillbirth and the resulting resisting attachment and protecting were protective mechanisms which allowed informants to cope with the process of livebirth following stillbirth.

In fearing recurrence of loss, informants were preparing to cope should another loss occur. Resisting attachment was also a protective mechanism, but one that did not negate their extreme desire for a child. Indeed, it would appear that the previous stillbirth enhanced the informants' value of a child and of mothering a child. Resistance to attaching in the immediate postnatal period appeared to be a normal consequence of fearing recurrence of loss. Time was required for the informants to resolve their fear of recurrence of loss, resume the attaching process, and gain confidence and competence in the mothering role. Being overprotective appeared to be a normal response to the circumstances as did the recurrence of residual grief over the lost child. It was important that informants differentiate the live child from the lost child in order to establish a relationship with the live child.

Pathological response to the birth of a live child following a stillbirth might occur if the mother was unable to differentiate the live child from the lost child and acknowledge the lost child. This might result in prolonged resistance to attachment with the live child. Failure to complete the grieving of the lost child might continue to delay attaching to the live child predisposing the child to child abuse (Lewis, 1979a). Another pathological response might be if the overprotectiveness is carried to the extreme or is prolonged as is evident with the vulnerable child syndrome (Green & Solnit, 1964). Persistence of resisting attachment or overprotectiveness would be cause for alarm.

Clinical Implications

The clinical implications for nursing are many and varied. Hospital and public health nursing staff can assess and evaluate behaviour and document the mother's progress toward establishing a positive relationship with her infant.

In the situation of stillbirth, facilitating acknowledgement of the stillborn child by encouraging the mother to see and hold her baby, name the baby, and have a funeral for the baby, would appear to be advantageous in differentiating the lost child from the fetus and child in the next pregnancy. Providing the mother with tangible memories of her child such as footprints of the child, a lock of hair, name-bands or pictures is similarly important.

It is preferable that nurses acknowledge a woman's desire to mother a child and to replace the lost child immediately following the stillbirth. At the same time encouraging the woman to take time to recover both physically and emotionally before embarking on another pregnancy may be helpful. Perhaps the best approach would be to listen and provide support to the mother while she decides what is best for herself.

In the pregnancy following the stillbirth, an important nursing intervention is to acknowledge a woman's feelings. Assessing for fearing recurrence of loss, anxiety, unreality of being pregnant, concealing the pregnancy, resisting attachment, not preparing for the baby, fear of labour and delivery, and guilt over the previous stillbirth, can help to alleviate the woman's guilt and reassure her that any or all of these feelings are normal under the circumstances.

It is important to provide women with reassurance of fetal wellbeing antenatally and infant wellbeing postnatally. Nurses must be aware of the increased significance that antenatal screening procedures and postnatal checks on the baby have for these mothers. Over enthusiasm needs to be avoided. There is a need to be sensitive to the guarding these women are doing.

Nurses must also be aware that these women are reliving the loss as they go through the next pregnancy. Events such as outpatient non-stress testing or being admitted for labour and delivery evoke feelings of residual grief and fearing recurrence and therefore women require additional emotional support. It is important to acknowledge the previous loss antenatally, intra-natally and postnatally. Women appreciate it when nurses understand their situation and will provide them with the appropriate physical and emotional support. Women look for both competence and empathy in nurses who provide care.

In intrapartum care it is appropriate for nurses to realize that labour and delivery is very threatening to these women. Women find induction of labour prior to term particularly threatening. Nurses cannot assume that these women are excited about the prospect of delivery. These women wish to have competent physical care of the unborn child during labour but often prefer not to have talk centre around the baby. Actually pushing the baby out may be a traumatic experience for the women and they may require additional support to overcome their resistance. Nurses can acknowledge that not all women will be ecstatic following the successful delivery of a live child. The interaction between the mother and her baby should proceed at the mother's own pace. Some women may be very anxious to hold their baby while other women may not wish to hold or breastfeed their child for a while. Nurses should realize that resistance to attachment at this point in women who have previously had a stillbirth would appear to be a normal response. The nursing staff can however, have the baby immediately available to the mother following delivery so that she can be reassured of the infant's wellbeing. Verbal reassurance may not be sufficient, but rather the mother should be permitted to view her infant in its' entirety if she wishes. This is equally important for women who have delivered under general anaesthetic. They should be permitted to view their infant as soon as they wish.

In order to alleviate the mothers' feelings of guilt, nurses should create an understanding environment in which a different pace of attaching is understood and accepted.

Mothers should be informed that residual grief over their lost child is normal, as is comparing and contrasting the two children. Nurses should recognize that any physical ailment of the infant will foster the mothers' fear of recurrence of loss and that even minor problems such as hyperbilirubinemia may be perceived by the mother as catastrophic and generate a fear of recurrence. Although these women are recorded as having a parity of two, they have no experience in mothering a live child and therefore require assistance and support in caring for their infant. Nurses can make sure the mothers are aware that lack of confidence in mothering is normal and that confidence and competence will gradually increase over time. In addition, mothers tend to feel inadequate that they have not prepared for the child and feel ill prepared to care for the child at home. They need reassurance that little is needed to care for a child and that there will be sufficient time to organize a nursery once they are home.

Finally, throughout the pregnancy following a stillbirth, women need to be aware that it is normal to have contradictory feelings: to be excited over the pregnancy yet frightened to be pregnant again, to have confidence that the unborn child will be born healthy but fearing recurrence of loss, to want desperately to love this child yet fearing to become attached. Caregivers also need to understand these processes.

Knowledge of the process of livebirth following a stillbirth can be used by nurses in planning, implementing and evaluating appropriate care for women during a subsequent pregnancy and following the live birth.

INDICATIONS FOR FURTHER NURSING RESEARCH

Using the qualitative method of grounded theory to generate a beginning theory regarding the process of livebirth following stillbirth stimulated the development of further questions to be researched. The sample selection criteria restricted the informants participating in this study to women who could speak and read English, women in a supportive relationship, and women over the age of 21. Future research should be conducted to determine:

1) What is the process of livebirth following stillbirth for adolescent mothers?
2) What effect does cultural variation have on the process of livebirth following stillbirth?
3) What is the process of livebirth following stillbirth for women not involved in a supportive relationship?

While it was possible in this study to conduct a limited comparison of the process of livebirth following stillbirth for primigravidas versus multiparas, investigation of the effect parity has on the process of livebirth following stillbirth should be investigated in more detail and with a larger sample size.

Similarly, although some comparison was made between livebirth following stillbirth and livebirth following early neonatal death, further investigation of the effect of the type of loss on subsequent pregnancies should be carried out. In addition, investigation of the effect of multiple losses is warranted.

Primary informants were first interviewed at a gestational age beyond 34 weeks. The earliest an alternate informant was interviewed was 23 weeks gestation. In order to gain a broader understanding of the process of livebirth following stillbirth, beginning interviewing earlier in pregnancy would be advisable. Indeed, valuable information would be gained by conducting a prospective research project with informants being enroled in the project following a stillbirth so that information could be collected both on the grieving process with the stillborn child and in the subsequent pregnancy.

The investigator was unable to find any research which investigated the experience of livebirth following stillbirth from the fathers' perspective. Further research in this area is recommended.

The two informants who did not become pregnant within six months of the occurrence of the stillbirth stated that one of the reasons they delayed pregnancy was to have time to grieve the lost child. It would be useful to conduct further research to determine what effect length of time between pregnancies has on the process of attaching to a livebirth following stillbirth.

The purpose of this research study was to identify and describe the perinatal maternal processes that occur with livebirth following stillbirth. The information gathered on the attachment between informants and their unborn children and their neonates was grounded in the self report of the informants and through field notes recorded by the investigator.

These informants were from varying backgrounds and sought antenatal care from a number of different physicians. It would be helpful to replicate this study in another geographical area to determine whether there were any regional differences that impacted on the process of livebirth following stillbirth.

STRENGTHS AND LIMITATIONS

A strength of the research study was the purposive sampling method used; informants were selected for the contribution they could make toward an understanding of the process of livebirth following stillbirth and this resulted in rich and relevant data. Theoretical sampling contributed to the richness of the data; the primary informants were homogeneous in having had a stillbirth in their first pregnancy and now being pregnant for the second time, being married, having post-secondary education, and having incomes above $20,000 annually. In addition they were all interviewed at the same points in their pregnancy.

The alternate informants contributed greatly to the theory generated because of the variation they provided in the areas of parity, type of perinatal loss, age, stability of relationship with partner, income, education, time passed since the loss occurred and the variation in the gestational age at which they were interviewed. Although all informants could speak and read English, there was cultural variation among them.

Although there was variation in the gestational age at which the alternate informants were interviewed, no informants were interviewed in the first trimester of pregnancy. The study design could have been strengthened by interviewing informants beginning in the first trimester and continuing to interview them at suitable intervals throughout the pregnancy. The study design could have been further strengthened if the experiences of the women in livebirth following stillbirth had been compared to the experiences of women who are pregnant and have not previously lost a child.

All data collection, transcribing, and data analysis was done by the investigator. Familiarity with the data greatly facilitated the data analysis process and was of paramount importance in ensuring the theory generated was grounded in the data. Familiarity of the investigator with the perinatal clinical area contributed to recognizing, understanding and documenting the process of livebirth following stillbirth.

A further strength of this research study was that interviews with the primary informants were conducted prospectively in order to come to an understanding of the dynamic process of livebirth following stillbirth. This contributed to richness of data that might have been lost had the study been conducted retrospectively following the livebirth.

PROPOSITIONS

Based on the findings of this study the following propositions were formulated:

1) Although women who experience a stillbirth are deprived of knowing the live child, they have been in the process of transforming to motherhood and attaching to that child and consequently the loss is devastating to them.

2) Women who have previously experienced a stillbirth fear recurrence of perinatal loss in subsequent pregnancies and need reassurance from nursing staff regarding fetal wellbeing antenatally and reassurance regarding the health of the newborn postnatally.

3) The anxiety women feel in pregnancy following a stillbirth because of their fear of recurrence of loss is overwhelming, therefore, women need empathy, understanding, and emotional support from nursing staff during the antepartum, intrapartum and postpartum periods.

4) As a consequence of fearing recurrence of loss, women who have previously had a stillbirth resist attaching to the unborn child in subsequent pregnancies and to the neonate in the early postpartum period and may take more time to get involved.

5) In the pregnancy immediately following stillbirth women attempt to replace the stillborn child but part of the process which occurs in the postpartum period is a need to conjointly establish a positive relationship with the live child and acknowledge the stillborn child.

It is hoped that this beginning theory regarding the experience of women during pregnancy and birth following a stillbirth can be a foundation on which further nursing research can be built. Furthermore, it is hoped that such research will improve the nursing care provided to such women and their families.

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APPENDIX A

INFORMANT GROUPS

Primary Informants:
Interviewed three times
1) 34 weeks gestation to term
2) within two weeks postpartum
3) Between four and six weeks postpartum

Grace * Tina * Helen * Sally

Alternate informants: Either did not exactly meet the primary subject selection criteria or were not due to deliver until July/August.
Interviewed only once.

Sarah * Linda * Marie * Rita * Carla

Secondary Informants: Interviewed once to verify the theory and model generated.

Lucy * Cindy

APPENDIX B

DEMOGRAPHIC INFORMATION

SUBJECT	AGE	EDUCATION	MARITAL STATUS	OCCUPATION
Grace	34	college	married	daycare worker/ housewife
Tina	23	college	married	nurse
Helen	39	university	married	business manager/ housewife
Sally	37	university	married	real estate agent
Sarah	26	university	married	accountant/ student
Linda	24	grade 8	common law	unemployed
Marie	29	grade 12	married	housewife
Rita	29	college	married	travel informant
Carla	34	university	married	hotel manager
Lucy	?	grade 12	married	housewife
Cindy	25	grade 9	married	student

APPENDIX C

CHARACTERISTICS OF THE PERINATAL LOSS

SUBJECT	LOSS DATE	SEX	GESTATIONAL AGE	CAUSE
Grace	Feb 1988	F	28 weeks	unknown
Tina	Feb 1988	M	38 weeks	knot in cord
Helen	Aug 1986	M	28 weeks	toxaemia
Sally	March 1988	M x 2	40 weeks	knot in cord
Sarah	April 1988	M	40 weeks	anencephaly
Linda	August 1987	M	27 weeks	abruptio placenta
Marie	April 1986	M	26 weeks	toxaemia
Rita*	Dec 1986	F	33 weeks	hypoxemia
Carla*	Sept 1980	M	25 weeks	PROM
Cindy	Nov 1983	F	20 weeks	corded
Lucy	1958	F	40 weeks	diaphragmatic hernia

* neonatal death

APPENDIX D

INTERVIEW SCHEDULE

Grace
Interview #1 - 34 weeks gestation
Interview #2 - 2 weeks postpartum
Interview #3 - 6 weeks postpartum

Tina
Interview #1 - 36 weeks gestation
Interview #2 - 3 days postpartum
Interview #3 - 5 weeks postpartum

Helen
Interview #1 - 36 weeks gestation
Interview #2 - 1 week postpartum
Interview #3 - 5 weeks postpartum

Sally
Interview #1 - 34 weeks gestation
Interview #2 - 2 weeks postpartum

Sarah
Interview #1 - 23 weeks gestation

Linda
Interview #1 - 26 weeks gestation

Marie
Interview #1 - 26 weeks gestation

Rita
Interview #1 - 23 weeks gestation

Carla
Interview #1 - 28 weeks gestation

Cindy
Interview #1 - 31 weeks gestation

Lucy
Interview #1 - not pregnant
31 years post-stillbirth

APPENDIX E

DEMOGRAPHIC DATA SHEET

In order to help me understand my findings I would like you to provide me with some personal information. If there are questions you do not want to answer, please let me know. All information will be handled in a confidential manner and although the information will be included in the final report, it will be done so that you will not be identified.

How old are you?______________________

What is or was your occupation?__________________________

If unemployed: Is your unemployment intentional?______

What is the age of the baby's father?_________________

What is his occupation?_______________________________

What is your ethnic background?-----------------------------

If Canadian: Are you a first generation Canadian?_____

If yes: Where did your parents come from?____________

In which of the following categories does your family income fall?

- ___Less than $5000
- ___$5000-$10,000
- ___$10,000-$20,000
- ___$20,000-$50,000
- ___More than $50,000

What was the highest education you obtained?

- ___grade school
- ___junior high school
- ___high school
- ___post secondary school
- ___university How many years?____ Highest degree?____

In what year did you lose your first baby?______________

How many weeks pregnant were you when you lost the baby?____

What is the reason that you were given?___________________

APPENDIX F

GUIDING QUESTIONS

Antenatal Interview:

Tell me about you and your baby.

How are you feeling about the upcoming birth?

How does this pregnancy compare to your earlier one?

Tell me about any concerns you have about this baby.

Does the loss of your first child make you afraid that something will happen in this pregnancy?

First Postpartum Interview:

Tell me about your labour.

Tell me about how you felt after the baby was born.

How did you feel when you first held your baby?

Did you have any concerns about this baby?

How did this labour compare to your earlier one?

Because of the loss of your first child, were you afraid that something would happen to this baby?

Second Postpartum Interview:

Tell me about you and your baby.

How are things between you and your baby?

How are you getting to know your baby?

What things do you think affect how you relate to your baby?

Do you think your previous loss affects how you relate to your baby?

APPENDIX G

CONSENT FORM

Project Title: Livebirth Following Stillbirth: The Process
of Maternal Infant Interaction

Investigator: Elizabeth Ann Lever B.N. R.N.
M.N. Candidate
Faculty of Nursing
University of Alberta
433-4344

Thesis Supervisor: Dr. Peggy Anne Field
Professor
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The investigator is a graduate student in the Masters of Nursing Program at the University of Alberta and the study is part of the requirements for the M.N. Degree. Nurses are interested in how mothers get to know their infants following birth. The purpose of the study is to increase nurses's understanding of how mothers who have previously had a stillbirth get to know their infants born in later pregnancies.

I understand that I will be asked to describe how I feel about my pregnancy and newborn infant. I understand I will be interviewed 3 or more times. The interviews will be in my home, one during the last six weeks of pregnancy, one in the first week after my baby is born, and one when my baby is 4 to 6 weeks old. Each interview will last anywhere up to 1 to 1 1/2 hours. The total time involved in the study will be about 5 hours.

I understand that each interview will be tape recorded by the investigator. I understand that subject to the provisions of the Child Welfare Act information will remain confidential. Besides the investigator, the typist will listen to the tapes and the thesis committee members will read the typed interviews. The tapes and the typed interviews will be kept in a locked drawer until the study is completed at which time they will be destroyed. A final report will include quotations from the interviews but my name will not appear in the report.

I understand the investigator is not a member of the hospital staff and will not disclose my responses to any of the hospital personnel. I understand the research will involve talking about my previous pregnancy. If I become upset I can ask to stop the interview at any time. If this occurs and I wish to have further contact with a qualified support person, the investigator will provide me with the name of a qualified counsellor.

I understand that I may not benefit from this study but that my participation may be helpful to other mothers and infants in the future.

This is to certify that I, ____________________________
(Print Name)
have given may consent to participate as a volunteer in the above research project. The investigator has explained to me the purpose of the study and what is involved. All my questions have been answered and I understand I can call the investigator at any time if I have questions or concerns.

I give permission to be interviewed and I understand that the interviews will be taped. I understand that my name will not be included in the report and that the tapes and typed interviews will be destroyed once the study is completed.

I understand that I have the right not to answer any questions I do not wish to answer and that I can drop out of the study at any time without affecting the medical and nursing care of myself or my infant.

I have a copy of this consent form.

____
Participant   Date_________

____
Investigator

APPENDIX H

NURSING IMPLICATIONS REGARDING STILLBIRTH

1) Informants who were diagnosed with intrauterine fetal death prior to labour expressed the desire to have a nurse they could call for support during those difficult days before delivery.

2) Informants with a known intrauterine fetal death appreciated understanding and compassion they received from the nurses who cared for them.

3) Informants appreciated nurses who recognized and supported their need to grieve for the stillborn child.

4) Informants did not wish to labour in a room with other women. They did not wish to return to the same antepartum room following delivery. They also did not wish to be in a room with other postpartum mothers. Even when they were assigned to a private room they hated to hear babies crying and disliked passing the nursery.

5) Informants appreciated that their husbands could stay with them overnight following occurrence of the stillbirth. They appreciated nurses providing them with blankets and pillows.

6) Informants appreciated having the opportunity to see and hold their babies. They appreciated receiving pictures of their child.

7) Informants did not want to be told that they could have other children or to be told to get pregnant right away.

8) Informants wanted follow-up and continued support following discharge from the hospital.